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Diagnostic discrepancies between ICD-10 and DSM-IV in personality disorders

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Introduction. 50 % of the patients seen in the mental health clinics have personality disorders and their diagnosis is very important to establish the patient's prognosis and treatment. The clinician usually only uses one nosology, the ICD-10 or the DSM-IV and is aware of the differences between them. However, he/she gives preference to his/her favorite nosology.

Material and method. A total of 248 patients seen in a mental health clinic were included in the study. They were diagnosed of anxiety (n = 121) and depressive (n = 127) disorders, with a mean age of 32.3 years for anxiety disorders and 32.4 years depressive disorders. The Interpersonality Disorder Examination (IPDE) Screening Questionnaire in its DSM-IV and ICD-10 versions was administered to observe the degree of concordance between the two nosologies.

Results and discussion. The female population predominated in our sample, these being 35.5 % men with anxiety disorders and 65,5 % women, and 29.10 % men and 70.9 % women with depressive disorders. An observational study was performed by studying the percentage with 3 or more positive items and also percentage with 6 or more positive items. It was observed that the DSM-IV version produced more positive diagnoses and more comorbidity. Thus, it is necessary to consider whether the ICD-10 version subdiagnoses personality disorders or the DSM-IV version gives false positives. The qualitative differences between the ICD-10 and the DSM-IV must also be considered. The ICD-10 does not include narcissistic and schizotypal personality disorders and subdivides the borderline personality disorder into two subcategories, so that a given patient can receive different diagnoses according to the nosology used .

Conclusions. In the patient sample studied, diagnostic discrepancies in personality disorders between DSM-IV and ICD-10 are so important that the WHO and the APA should consider unifying categories and diagnostic criteria of personality disorders in the next nosologies .

Key words:
Personality disorders. IPDE. IPDE-DSM-IV. IPDE-ICD-10. Diagnostic agreement.

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Discrepancias diagnósticas entre la CIE-10 y el DSM-IV en los trastornos de la personalidad

Introduccion. Un 50 % de los pacientes vistos en salud mental presentan trastornos de la personalidad; su diagnóstico es fundamental para el pronóstico y tratamiento de los pacientes. Habitualmente el clínico utiliza una de las nosologías, o la CIE-10 o la DSM-IV; es consciente de las diferencias entre ambas, pero da por buenos los resultados obtenidos con su nosología preferida.

Material y método. Se incluyeron en el estudio 248 pacientes vistos en un centro de salud mental con trastornos de ansiedad (n = 121) y trastornos depresivos (n = 127), con una media de edad de 32,3 años para los trastornos de ansiedad y 32,4 años para los pacientes depresivos. Se les administró el Cuestionario de Screening IPDE en sus dos versiones, DSM-IV y CIE-10, para observar el grado de concordancia entre ambas nosologías.

Resultados y discusión. En la muestra obtenida fue predominante la población femenina en tratornos de ansiedad (35,5 % hombres y 65,5 % mujeres) y en tratornos depresivos (29,10 hombres y 70,9 mujeres). Se realizó un estudio observacional en el que se valoró el porcentaje con tres o más ítems positivos y también el porcentaje con seis o más ítems positivos; es destacable que se obtiene mayor número de diagnósticos positivos y de comorbilidad con el la versión DSM-IV del cuestionario de Screening IPDE, por lo que se presenta la duda sobre si la CIE-10 subdiagnostica trastornos de la personalidad o la DSM-IV da falsos positivos. Además hay diferencias cualitativas; el que la CIE-10 subdivida en dos el trastorno límite de la personalidad, no incluya el trastorno narcisista de la personalidad y considere al o esquizotípico de la personalidad una psicosis hace que un paciente pueda recibir diferentes diagnósticos según se empleen criterios DSM-IV o CIE-0.

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Conclusiones. En la muestra estudiada de pacientes las discrepancias diagnósticas entre los trastornos de la personalidad con la DSM-IV y la CIE-10 son tan importantes que la OMS y la APA deberían considerar en las próximas nosologías la unificación de las categorías diagnósticas y los criterios diagnósticos en los trastornos de la personalidad.

Palabras clave:
Trastornos de la personalidad. IPDE. IPDE-DSM-IV, IPDE-CIE-10. Concordancia diagnóstica.

INTRODUCTION

The concept «personality disorder» has been the object of great controversies, constituting one of the greatest theoretical and practical questions of Clinical Psychiatry in recent times. It is now when the concepts begin to be consolidated, although there are still many unexplained aspects.

Personality may be understood as the dynamic organization of the biological and psychological aspects that characterize one person and distinguish him/her from another. Personality disorders make up forms of rigid, permanent, deep rooted and maladaptive behavior of the subject. They represent deviations or variations from normality, both due to excess as well as defect, that give rise to maladaptive and consolidated patterns of behavior that are stable in time, and that cause significant subjective malaise and function deterioration for the subject or third parties.

In regards to the epidemiology, it is not easy to establish the personality disorders prevalence values. The studies performed in this sense in this field are limited. Difficulties to establish incidence and prevalence values are basically found within the problems to perform differentiated diagnoses, given the high frequency with which personality disorders overlap between themselves and with other mental disorders.

Neugebauer et al.[1] (1980) analyzed the epidemiological studies published in Europe and the USA since 1950. Mean prevalence found was 7 %. In a joint review of several studies with standardized interviews and DSM-III-R criteria, Weissman[2] (1990) found rates that ranged from 10 %-13 % of presence of personality disorders in the general population, without any important difference between genders, except for some specific personality disorder. One study published by Samuel et al.[3] (1994), with 810 adults interviewed by psychiatrists, using a semistructured instrument with DSM-III diagnostic criteria, shows a 5.9 % prevalence with greater presence among males who were separated and scarce comorbidity between the different personality disorders. On the other hand, the Casey and Tyrer[4] studies (1986) offered much higher prevalence results as they were formulated in primary health care: 34 % of the personality disorders.

To conclude, it can be stated that the disorder due to dependency is the most frequent in the general population, followed by schizotypal. Antisocial, schizotypal, schizoid and narcissistic disorders are more frequent in men, while borderline and dependence disorders are more frequent in women. Borderline PD is the one that is most frequently associated in comorbidity with other personality disorders[5].

At present, there are several diagnostic instruments (PAS, SCID-II, MMPI-2, etc.), some being in the form of semistructured interviews and other in test form. We used the IPDE for our study, both in its ICD-10 as well as DSM-IV form, as it is the only one endorsed by the WHO, and in its «short» form due to its ease of use, both diagnostic as well as for the patient, as it is a self-applied test. This a screening test, not aimed at elaborating diagnoses. As it is a «double» test, it makes it possible «to compare» and it verifies DSM-IV or ICD-10 diagnostic criteria.

In turn, 50 % of the patients who come to their mental health team have underlying personality disorders that condition the picture course. That is why the IPDE stands out as a good screening tool to assess traits, together with the clinician's diagnostic opinion for better orientation of the patient's treatment (pharmacological and psychotherapeutical).

In our daily clinical practice, we have administered the short IPDE to every patient who came to the clinic for the first time during the last 4 years and we have commented the results with the patient in question.

To our surprise, when the DSM-IV IPDE and ICD-10 IPDE have been administered, we have verified that the correspondence is not complete between both of them and that, in many cases, subjects who respond to criteria of a specific disorder in one of the classifications do not fulfill those of the equivalent disorder in the other. Furthermore, the ICD-10 does not contemplate some disorder modality existing in the DSM-IV, such as the narcissistic disorder. However, it contemplates the unstable personality with its two subtypes, borderline and impulsive. Nonetheless, do these correspond with the DSM-IV borderline disorder? There are reasonable doubts on whether they do or do not measure the same thing.

One of the greatest obstacles that we find when establishing the diagnosis is the difficulty to define the normality concept and to distinguish the limit between trait and disorder. Traits constitute tendencies to act in a similar way in certain situations. When the traits appear constantly and with marked intensity, they give rise to typical behaviors and behaviors from which the criteria that determine the diagnosis of the disorder itself are drawn. However, the reality is that the diagnostic and nosological elements that we presently have do not make it possible to solve this problem in a completely satisfactory way.

On the other hand, high comorbidity between personality disorders, coded in axis II, and the coded disorders on axis I in the DSM nosologic system, is found. In fact, for

many years, authors have considered personality disorders as minor forms of an equivalent larger disorder[6].

The fact that most of the patients who come to the mental health teams suffer anxious and/or depressive disorders leads us to focus on these semiological groups, ruling out the rest that is less prevalent.

In relationship with the affective disorders, a frequent association has been found between depression and borderline personality disorder (Akiskal, 1981). Dysthymic and cyclothymic patients seem to have a greater frequency of personality disorder than the remaining patients with depressive disorders[7]. The most common personality disorders in dysthymic patients are borderline, histrionic and avoidant personality disorder[8].

In regards to anxiety disorders, it is calculated that there is an underlying personality disorder, generally group C (Stein, 1990; Pollack,1992; Sanderson, 1994; Noyes, 1994), in approximately 35 %-40 % of the cases. It has been verified that the anxiety-personality disorder association has worse response to treatment, worse global functioning and tendency to relapse and chronicity[9].

MATERIAL AND METHOD

The sample was obtained among those who requested care in the out-patient health center from a subsector of 60,000 inhabitants.

Inclusion criteria

- Patients who come to this out-patient clinic for the first time.
- When the reason for consultation is based on anxious, depression or both semiology complaints.

Table 1 Cut-offs for each category (DSM-IV)

Categories	Cut-off
Paranoid	4 of 7
Schizoid	4 of 7
Schizotypal	5 of 9
Histrionic	5 of 8
Antisocial	3 of 7
Narcissistic	5 of 9
Bordeline	5 of 9
Obsessive-compulsive	4 of 8
Dependent	5 of 8
Avoidant	4 of 7

Table 2 Cut-offs for each category (ICD-10)

Categories	Cut-off
Paranoid	4 of 7
Schizoid	4 of 9
Histrionic	4 of 6
Dissocial	4 of 6
Impulsive	3 of 5
Borderline	3 of 5
Anancastic	4 of 8
Dependent	4 of 6
Anxious	4 of 6

- Ages ranging from 18 to 65 years.
- Sufficient capacity of understanding and reasoning to read and interpret the questionnaire.

A total of 320 patients was obtained. Of these, 121 were diagnosed of anxiety disorder and 127 of depressive disorder.

All the subjects were administered the self-applied assessment questionnaire of personality disorders IPDE ICD-10 and DSM-IV version10.

An observational study of the subpopulations was performed. It considered:

- Number of subjects and % who have three or more positive items.
- Number of subjects and % who have six or more positive items.

The WHO establishes the existence of three or more positive items of the questionnaire as cut-off to consider a specific category as significant. This low cut-off increases the rate of false positives at the expense of, of course, increas-

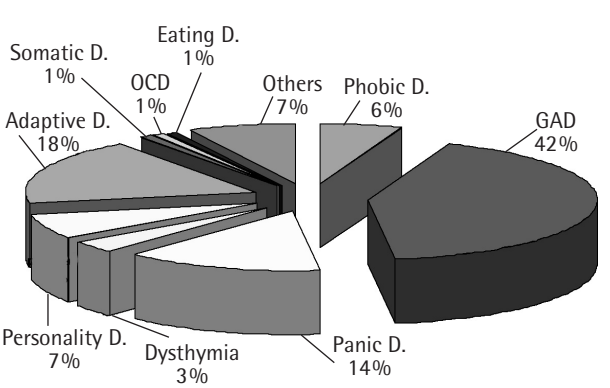

Figure 1 *Diagnoses of anxiety D. (I).*

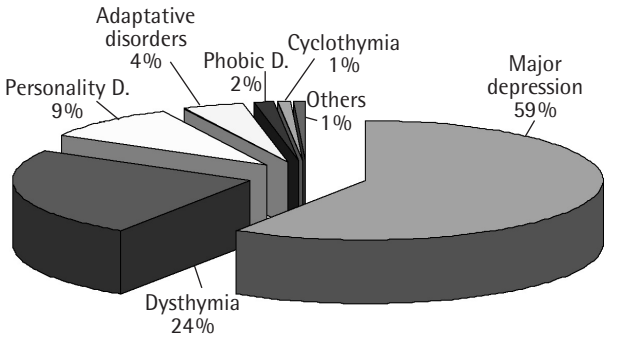

Figure 2 *Diagnoses of depressive D. (II).*

ing sensitivity (that is, it identifies as «possible» more cases than those which, after their study, will be verified as certain). This premise should occur in all screening tests or instruments: no case should «escape».

There are two possibilities to increase specificity (identify all those subjects as «healthy» who are susceptible of being it):

- Use the long IPDE (ruled out as its application is unviable in the daily consultation)
- Increase the cut-off (since both the DSM-IV and ICD-10 establish higher cut-offs than that agreed on by the WHO) (table 1 and 2).

Given the difference in number of positive items and in total number of them within each category, we agreed to propose six or more as the number of items necessary to increase specificity.

DISCUSSION

A total of 121 were diagnosed of Anxiety disorders and 127 of depressive disorders out of the 320 patients who were administered the IPDE questionnaire. This is shown in figures 1 and 2.

Table 3 **Anxiety (DSM-IV)**

	Three or more positive items	Six or more positive items
Paranoid	39 (32.33 %)	5 (4.13 %)
Schizoid	39 (32.33 %)	1 (0.8 %)
Schizotypal	26 (21.5 %)	4 (3.3 %)
Histrionic	70 (57.8 %)	8 (6.6 %)
Antisocial	10 (8.26 %)	0 (0 %)
Narcissitic	49 (40.45 %)	10 (8.26 %)
Bordeline	81 (67 %)	27 (22.3 %)
OC	80 (66.1 %)	13 (10.74 %)
Dependent	38 (31.4 %)	9 (7.4 %)
Avoidant	86 (71 %)	30 (24.8 %)

Regarding gender and age, the results in both samples are very similar: 35.5 % (43) «anxious» men versus 29.1 % (37) «depressive» ones and 65.3 % (79) «anxious» women and 70.8 % (90) «depressive» ones. AGE range is found between 18 and 65 years (exclusion criterion) with a mean for anxiety of 32.3 and for depression 32.4.

To continue with the presentation of the results, we break down the population into the anxiety and depression subgroups in order to reflect them clearly. As can be observed, there are large discrepancies between the scores obtained with the DSM-IV IPDE and the ICD-10 IPDE. These discrepancies are categorial, such as suppression of the «narcissistic» or «schizotypal» category or the dissection made by the ICD-10 in the «borderline» category (borderline and impulsive).

What could this be due to?

We will attempt to propose some reflections prior to the presentation:

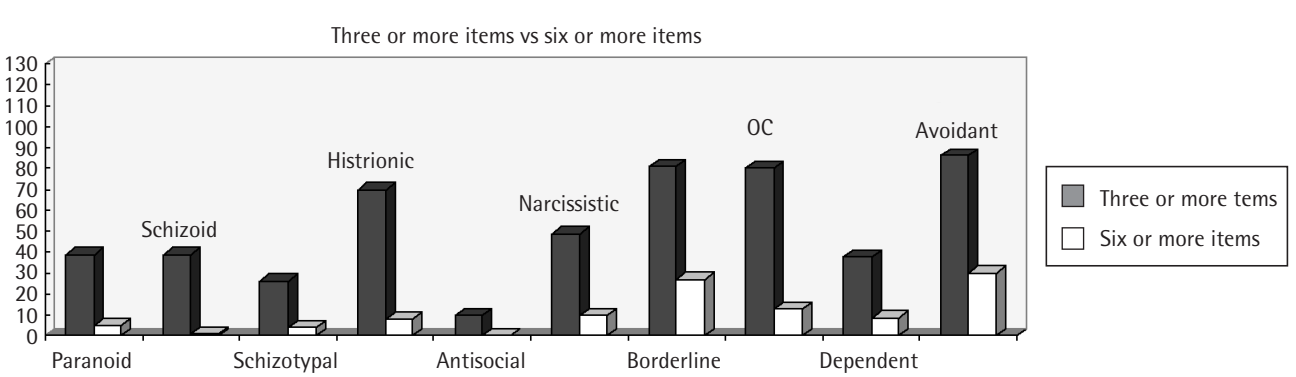

Figure 3 *Anxiety (DSM-IV).*

Table 4 (Anxiety ICD-10)

	Three or more positive items	Six or more positive items
Paranoid	24 (19.83 %)	4 (3.3 %)
Schizoid	77 (63.63 %)	10 (8.26 %)
Dissocial	7 (5.78 %)	0
Impulsive	33 (27.2 %)	0
Bordeline	30 (24.79 %)	0
Histrionic	40 (33.05 %)	2 (1.65 %)
Anancastic	78 (64.46 %)	16 (13.2 %)
Anxious	74 (61.15 %)	9 (7.4 %)
Dependent	65 (53.71 %)	1 (0.8 %)

- Where are the individuals listed as «schizotypal» or «narcissistic» placed in the ICD-10?
- Is this overlapping of diagnoses therapeutically useful?
- Is there an excess of categories in the DSM-IV or a lack of them in the ICD-10?
- Are they necessary for a different therapeutic approach?
- Do we diagnose the same patients with both classifications?

These questions can be extrapolated both for the anxious as well as depressive subgroup.

ANXIETY (table 3 and fig. 3 and table 4 and fig. 4)

Discussión of anxiety

In view of the data, we find greater prevalence of avoidant disorder (71 %) in those individuals with cut-off 3 and also in those with cut-off 6 (25 %). This result gives rise to the first discrepancy:

- What can we compare avoidant disorder to in the ICD-10 classification?
- To the anxious disorder? If this is true, the results also do not agree since the anticlastic disorder is more prevalent in both cut-offs (64.5 % and 13.2 %).
- The anxious disorder with cut-off 6 is only reflected in 7.5 % of those surveyed, one third of the avoidant. Where is the «supposed escape» of the avoidant patients distributed?
- It may be stated while the borderline patients correspond to 22 % (the 2nd in prevalence after the avoidant) in the DSM-IV with cut-off 6, there is no representation in the ICD-10.

Isn't it possible that all these differences may somehow condition the therapeutic approach of the patient according to the personal choice of the professional in choosing one correction or another?

DEPRESSION (table 5 and fig. 5 and table 6 and fig. 6)

Discussion of depression

There are greater percentages of patients who score in a category among the depressive subjects than the anxious ones, there being greater comorbidity between axis I and axis II.

This difference is more significant with the DSM-IV IPDE than with the ICD-10 one.

The difference of criteria repeats among the subjects affected by depressive semiology. The difference observed is once again especially outstanding between the DSM-IV and ICD-10. While the borderline patients correspond to 26 % in the DSM-IV cut-off 6, they have no representation in the ICD-10.

To complete the study, all those subjects who score six or more items in any category, both for the DSM-IV and

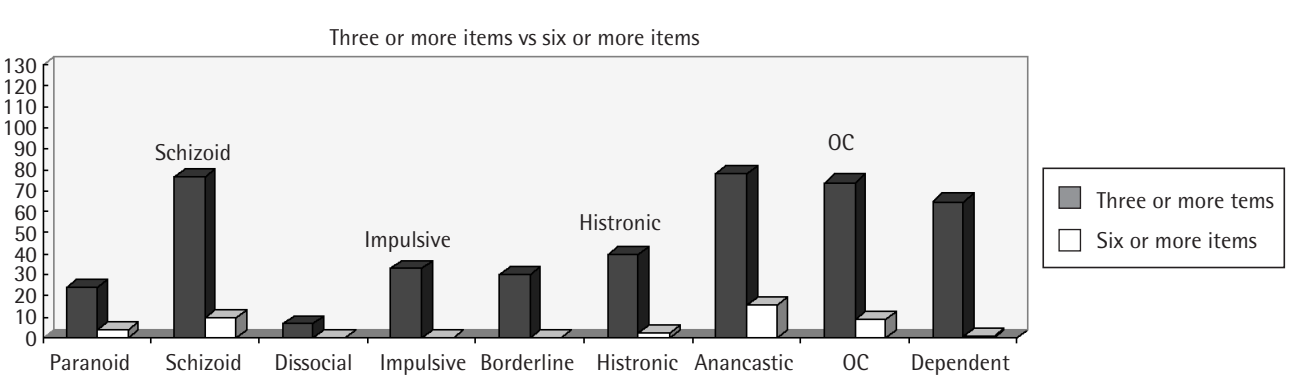

Figure 4 *Anxiety (ICD-10).*

Table 5 Depression (DSM-IV)

	3 or more positive items	6 or more positive items
Paranoid	56 (44.1 %)	9 (7 %)
Schizoid	67 (52.7 %)	3 (2.3 %)
Schizotypal	54 (42.5 %)	8 (6.3 %)
Histrionic	65 (51.2 %)	5 (4 %)
Antisocial	15 (11.8 %)	0
Narcissitic	58 (45.6 %)	8 (6.3 %)
Bordeline	101 (80 %)	30 (26.3 %)
OC	93 (73.2 %)	17 (13.4 %)
Dependent	69 (54.3 %)	9 (7 %)
Avoidant	100 (78.7 %)	48 (37.7 %)

ICD-10 and both for those having anxious and depressive semiology, were extracted. By doing so, what we want to see is the diagnostic similarity between the DSM-IV and ICD-10, that is, their «skill» to identify, with the same certainty index, those subjects with equivalent personality disorder in both diagnostic systems, which, as we have been stating during this presentation, is at a minimum.

Once identified, we also establish comorbidity between disorders, which, as Dolan et al. (1995) state: «the number of diagnoses per subject gives us an idea of the seriousness of the disorder of each subject»[11].

Tyrer and Johnson[12] prefer to speak in these cases of overlapping of diagnoses more than of true comorbidity and propose a new system to classify personality disorder severity into four categories (table 7).

At present, it is calculated that approximately two thirds of the patients with a diagnosis of a certain personality disorder also fulfill diagnostic criteria of another, although the question if this is really due to the existence of comorbidity between the personality disorders of if it deals with an error in the diagnostic instruments used must still be solved.

Anxiety

We have chosen the 2 most prevalent categories, these being avoidant (30, 50 %) and borderline (27, 45 %) and observe comorbidity regarding the most prevalent disorders (table 8).

The most prevalent association is avoidant-borderline (50 % regarding all individuals with avoidant disorder and 55.6 % regarding all individuals with borderline personality disorder) (table 9).

The most prevalent association is borderline-dependent (44.4 % of the «dependents» are borderline) from the point of view of the subjects with dependent and borderline-avoidant personality disorder (48.1 % of the borderlines are avoidant) from the point of view of the avoidant personality disorder subjects (table 9).

The minimum similarity in the capacity to detect subjects with equal disorder between ICD-10 and DSM-IV, especially in the borderline personality disorder (DSM-IV) and its homonyms of the ICD-10, stands out.

Comorbidity

DSM-IV

- No disorder in DSM-IV: 6 (10 %).
- One disorder: 20 (33.3%).
- Two disorders: 17 (28.3 %).
- Three disorders: 14 (23.3 %).
- Four disorders: 2 (3.3 %).
- Five disorders: 1 (1.6 %).

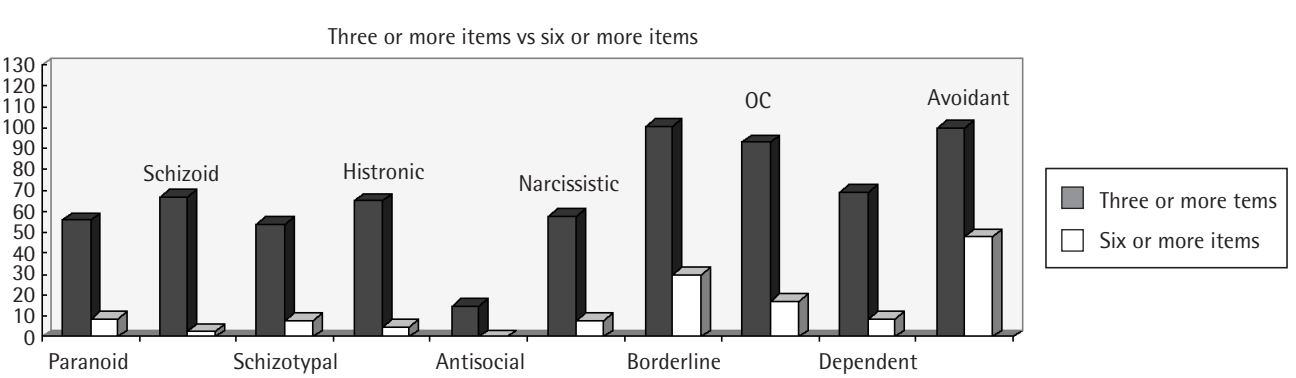

Figure 5 *Depression (DSM-IV).*

Table 6 Depression (ICD-10)

	3 or more positive items	6 or more positive items
Paranoid	60 (47.2 %)	8 (6.3 %)
Schizoid	69 (54.3 %)	16 (12.6 %)
Dissocial	11 (8.6 %)	0
Impulsive	38 (30 %)	0
Bordeline	44 (34.6 %)	0
Histrionic	43 (33.8 %)	2 (1.57 %)
Anancáastic	94 (74 %)	16 (12.6 %)
Anxious	88 (69.3 %)	12 (9.44 %)
Dependent	66 (52 %)	2 (1.57 %)

Table 7 New system for classification of personality disorder severity on four levels (Tyrer and Johnson)

Level	Classification	Result of evaluation
0	Without personality disorder	Without abnormal tratits
1	Personality difficulties	Criteria that do not reach threshold for a diagnosis
2	Simple personality disorder	One or more personality disorders of the same DSM-IV or CIE-10 group
3	Diffuse personality disorder	Two or more disorders of different groups

ICD-10

- No disorder in ICD-10: 26 (43,3 %).
- One disorder: 26 (43,3 %).
- Two disorders: 8 (13,3 %).

This agrees with many studies that state that more than 70 % of the patients have comorbidity between two, three or four disorders.

When our sample is analyzed, we verify a greater index of overlapping in the DSM-IV than in the ICD- 10:

- DSM-IV: three or more disorders: 28 % (1/3 of the sample).
- ICD-10: three or more disorders: 0 %.

Depression

- Total : 77 subjects.

We performed the same procedure, identifying those individuals whose score is equal to or greater than 8 in some category, both in the DSM-IV and ICD-10 IPDE version to thus locate the most prevalent disorder, its comorbidity with the remaining disorders and the overlapping between them afterwards (table 10).

The most prevalent disorder is the avoidant personality one, as in the case of anxiety (62.33 % of all the individuals with personality disorders of six or more items suffer it). The most frequent comorbidity/overlapping is with the dependent one (66.6 % of the subjects with dependent personality disorder also have an avoidant personality disorder) and the borderline personality disorder in regards to the avoidant ones (31.2 % of the individuals with avoidant disorder have a borderline disorder overlapping) (table 11).

The borderline personality disorder (39 %) appears in the second place. It is most frequented grouped with the histrionic disorder (80 % of those having histrionic disorder have an associated borderline disorder) (this association appears as the most prevalent in many studies) and with the avoidant one (46.6 % of the borderlines).

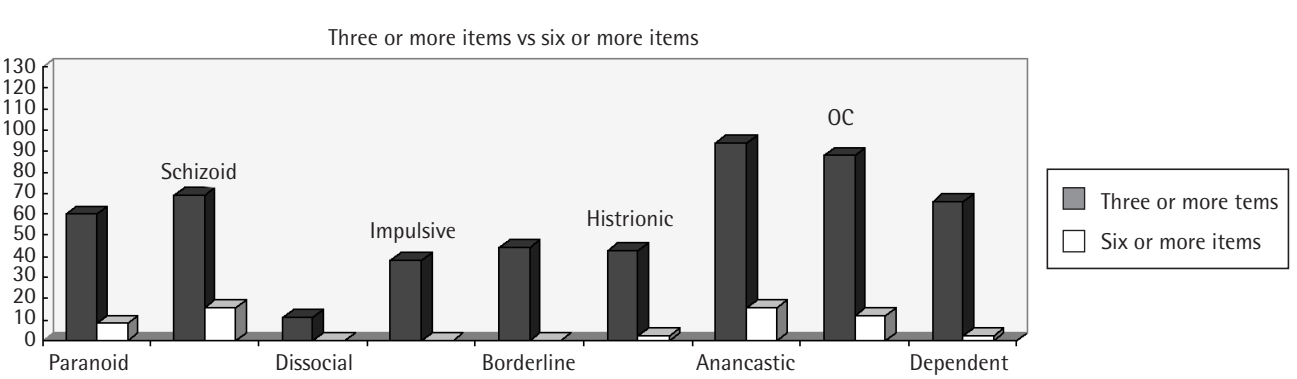

Figure 6 *Depression (ICD-10).*

Table 8 Comorbidity (anxiety) (I)

DSM-IV			ICD-10		
% regarding each subcategory	Subcategories and no. of subjects with avoidant	% regarding 30 avoidants	% regarding each subcategory	Subcategories and y no. of subjects with avoidant comorbidity	% regarding 30 avoidants
40 (5)	Paranoid: 2	6.7	20 (4)	Paranoid: 1	3.4
100 (1)	Schizoid: 1	3.4	60 (10)	Schizoid: 6	20
75 (4)	Schizotypal: 3	10			
(8)	Histrionic: 0		(2)	Histrionic: 0	
(0)	Antisocial: 0		(0)	Dissocial: 0	
40 (10)	Narcissistic: 4	13.3	(0)	Impulsive: 0	
55.6 (27)	Bordeline: 15	50	(0)	Bordeline: 0	
53.8 (13)	OC: 7	23.3	56,2 (16)	Anancastic: 9	30
	Dependent: 4	13.3	77,7 (9)	Dependent: 7	23.3
	Avoidant		100 (1)	Anxious: 1	3.4

Finally, comorbidity speaks of a certain preponderance of single disorders (simple disorder of personality or group 2 as Tyrer would state) as occurs in our sample with the ICD-10, but not with the DSM-IV, in the half of the sample that has two or more disorders.

Comorbidity

DSM-IV

- No disorder in DSM-IV: 4 (5.2 %).
- One disorder: 32 (41.55 %).
- Two disorders: 24 (31.16 %).
- Three disorders: 13 (16.9 %).
- Four disorders: 3 (3.89 %).
- Five disorders: 1 (1.29 %).

ICD-10

- No disorder in ICD-10: 33 (42.85 %).
- One disorder: 34 (44.15 %).

Table 9 Comorbidity (anxiety) (II)

DSM-IV			ICD-10		
% regarding each subcategory	Subcategory and no. of subjects with avoidant comorbidity	% regarding 27 bordelines	% regarding each subcategory	Subcategory and no. of subjects with bordeline comorbidity	% regarding 27 bordelines
20 (5)	Paranoid: 1	3.7	(4)	Paranoid: 0	
(1)	Schizoid: 0		40 (10)	Schizoid: 4	14.8
25 (4)	Schizotypal: 1	3.7			
(8)	Histrionic: 3	11.1	(2)	Histrionic: 0	
(0)	Antisocial: 0		(0)	Dissocial: 0	
40 (10)	Narcissistic: 4	14.8	(0)	Impulsive: 0	
	Bordeline			Bordeline: 0	
23 (13)	OC: 3	11.1	18.7 (16)	Anancastic: 3	11.1
44.4 (9)	Dependent: 4	14.8	44.4 (9)	Dependent: 4	14.8
43.1 (30)	Avoidant: 13	48.1	(1)	Anxious: 0	

Table 10 Comorbidity (depression) (I)

DSM-IV			ICD-10		
% regarding each subcategory	Subcategories	% regarding 48 avoidants	% regarding each subcategory	Subcategories	% regarding 48 avoidants
255.5 (9)	Paranoid: 5	10.4	37.5 (8)	Paranoid: 3	6.2
33.3 (3)	Schizoid: 1	3	62.5 (16)	Schizoid: 10	20.8
37.5 (8)	Schizotypal: 3	6.2			
20 (5)	Histrionic: 1	2	50 (2)	Histrionic: 1	2
(0)	Antisocial: 0		(0)	Dissocial	
25 (8)	Narcissistic: 2	4	(0)	Impulsive	
50 (30)	Bordeline: 15	31.2	(0)	Bordeline	
58.8 (17)	OC: 10	20.8	37.5 (16)	Anancastic: 6	12.5
66.6 (9)	Dependent: 6	12.5	0 (2)	Dependent	
	Avoidant		75 (12)	Anxious: 9	18.7

— Two disorders: 8 (10.38 %).

— Three disorders: 2 (2.59 %).

In the presence of such discrepancies, we can observe that the «small» differences between DSM-IV and ICD-10, when an effort is not made to use both tests, become large differences that make these questionnaires of little clinical use. This is because the review used determines what results will be obtained, with the consequent diagnostic distortion, or at least orientation, and, of course, the patient is the most affected, so that we feel that the subject should be studied by the WHO and the APA to rectify such problems.

CONCLUSIONS

— There are categorial differences between the DSM-IV and ICD-10 evaluation of the IPDE questionnaire.

— The categories that are repeated on both scales do not contain the same items, so that it could be considered that they do not diagnose the same thing, determining changes in the therapeutic approach.

— The categories that are not repeated:

- Are they included under another name?
- Are they undiagnosed patients, with the consequent therapeutic detriment?

Table 11 Comorbidity (depression) (II)

DSM-IV			ICD-10		
% regarding each subcategory	Subcategories	% regarding 30 bordelines	% regarding each subcategory	Subcategories	% regarding 30 bordelines
33.3 (9)	Paranoid: 3	10	75 (8)	Paranoid: 6	20
33.3 (3)	Schizoid: 1	3.3	37.5 (16)	Schizoid: 6	20
62.5 (8)	Schizotypal: 5	16.6			6.6
80 (5)	Histrionic: 4	13.3	100 (2)	Histrionic: 1	
(0)	Antisocial: 0		(0)	Dissocial	
62.5 (8)	Narcissistic: 5	16.6	(0)	Impulsive	
	Bordeline		(0)	Bordeline	
29.4 (17)	OC: 5	16.6	31.12 (16)	Anancastic: 5	16.6
33.3 (9)	Dependent: 3	10	50 (2)	Dependent: 6	20
29.1 (48)	Avoidant: 4	46.6	50 (12)	Anxious: 1	3.3

- Does the ICD-10 underdiagnose (based on the data obtained)?
- Is the DSM-IV very sensitive at the expense of increasing false positives or the ICD-10 very specific?
- If the IPDE is a screening material: it would thus be preferable for it to be more sensitive than specific.
- It is necessary and desirable to unify criteria in benefit of a better diagnosis and, as a consequence, a better therapeutic approach.

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