Introduction to and Update for the *International Classification of Diseases, 11th Revision*

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Key Points

Whereas *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* represents a categorical approach to mental health diagnosis, the *International Classification of Diseases, 11th Revision (ICD-11)* (World Health Organization, 2022) introduces the concept of a *boundary with other disorders*—including the threshold between normality and pathology—and adopts a dimensional approach to mental health diagnosis. *ICD-11* represents new alphanumeric coding that differs from *DSM-5-TR* and previous *ICD* revisions.

History of the *International Classification of Diseases*

The *ICD*, developed in the 19th century and preceding the *DSM* series, is the World Health Organization's global system for classifying diseases, disorders, and health conditions, enabling comparisons of health statistics across countries and over time. *DSM-5* marked the first time that a clear crosswalk was established between codes within *DSM* and *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*).

The World Health Organization (WHO) is responsible for overseeing revisions and the publication of the *ICD* series. The latest version is *ICD-11*, released January 1, 2022, which replaced *ICD-10*, which had been in use since 1992. As of 2025, 35 countries actively use *ICD-11*. Most significant updates to the *ICD* series occur approximately every decade, driven by advancements in medical knowledge and the need for more detailed coding to capture diagnoses accurately. Unlike the *DSM* series, which is devoted exclusively to mental health conditions and neurological disorders, *ICD* is a classification system for all diseases, with a section dedicated to mental health conditions. The United States has not indicated when it will officially update to *ICD-11*.

Key Points in the Development of *ICD*

1893: French physician Jacques Bertillon introduced *The Bertillon Classification of Causes of Death*, which served as the foundation for the subsequent *ICD.*

1898: The American Public Health Association recommended using Bertillon's system in the United States, Canada, and Mexico.

1900: The first international conference was held to revise *ICD*.

1946: WHO took over responsibility for *ICD*, facilitating international collaboration on revisions.

1977: *ICD-9* was published. This version marked a significant expansion in the number of codes and introduced a more detailed classification system.

1980s: The WHO significantly revised *ICD-9* because the work did not include diagnostic criteria or a multiaxial system; its purpose was to outline categories for the collection of basic health statistics. Because of dissatisfaction with the lack of specificity in *ICD-9*, a decision was made to modify it for use in the United States, resulting in *ICD-9-CM* (for *Clinical Modification*).

1993: *ICD-10-CM* was published.

2022: *ICD-11*, the most recent revision, incorporates new diseases, updated terminology, and a focus on digital interoperability. *ICD-11* was adopted by the WHO in 2019, and member countries began using it in 2022. As of 2025, there have been no established guidelines for implementing *ICD-11* in the United States, although 35 other countries have adopted it.

2025: The transition from *ICD-9* to *ICD-10* was completed on October 1, 2015, and *ICD-10*, which is aligned with *DSM-5* and *DSM-5-TR*, is still used for hospital billing and documentation in the U.S. Specifically, *ICD-10-CM* is used for diagnosis coding, while *ICD-10-PCS* is the version of the classification system used for inpatient procedures. *ICD-10*, which is aligned with *DSM-5* and *DSM-5-TR*, is still used for hospital billing and documentation in the U.S. Specifically, *ICD-10-CM* is used for diagnosis coding, while *ICD-10-PCS* is the version of the classification system used for inpatient procedures. The transition from *ICD-9* to *ICD-10* was completed on October 1, 2015.

Features of *ICD-11*

ICD-11 includes an updated classification system with a more comprehensive list of diagnoses than previous versions. *ICD-11* features enhanced coding with new codes for emerging diseases, such as COVID-19, and improved coding for mental health conditions. The global applicability of *ICD-11* has increased, as it is designed to be used by healthcare systems worldwide, promoting consistency in data collection and analysis. *ICD-11* also provides mapping tables to facilitate the transition from *ICD-10* to *ICD-11*.

There are numerous benefits associated with *ICD-11*. These include improved data quality and comparability across countries, enhanced research and monitoring of health conditions, improved clinical decision-making and treatment planning, and standardized reporting of diagnoses for healthcare systems.

Material within *ICD-11* Relevant to People with IDD

- *ICD-11* considers intellectual and developmental disabilities (IDD) to be a neurodevelopmental disorder, a group of conditions that impact learning, social skills, and motor functions.
- *ICD-11* uses severity qualifiers such as mild, moderate, severe, and profound to describe the level of impairment based on IDD.
- *ICD-11* includes guidance on how to diagnose new disorders, such as complex post-traumatic stress disorder.
- *ICD-11* includes culture-related guidance to help clinicians understand how disorders may present differently across cultural backgrounds.

ICD-11 Diagnostic Coding

ICD-11 contains alphanumeric codes for mental health conditions, which have been revised from *ICD-10-CM*. All codes contain a letter of the alphabet in the first position, which indicates the chapter in which the category was classified. Previously, the codes for *ICD-10* mental and behavioral disorders began with the letter "F." At a point that the Centers for Disease Control (CDC) determines, an American version of *ICD-11* will be released with clinical modifications; at that point, *ICD-11-CM* will replace *ICD-10-CM*.

ICD-11, like *ICD-10* and its predecessors, conveys diagnostic information based on the various positions and values of alphanumeric characters within a diagnostic code. The first character of an *ICD-11* code indicates the top-level chapter; for example, if the first character is a "6," the code is found in the mental, behavioral, and neurodevelopmental disorders chapter. The second and third characters taken together indicate the diagnostic class or grouping (e.g., 6A7 for depressive disorders, 6B0 for anxiety and fear-related disorders). The fourth character typically indicates the specific disorder within that class (e.g., 6A70 for single episode depressive disorder, 6A71 for recurrent depressive disorder), but in cases in which these numbers are more than 10, letters of the alphabet are used after the digits 0–9 are exhausted. For example, the fourth character in the *ICD-11* codes for disorders due to substance use indicates the substance class. Further, because *ICD-11* recognizes 14 different specific substance classes, the fourth character codes for the last four substance classes required letters (e.g., the code for disorders due to use of volatile inhalants is 6C4B). The fifth character (following a decimal point) generally indicates subtypes or specifiers applicable to that diagnosis (e.g., 6A70.0 for single episode, mild; 6A70.1 for single episode, moderate, without psychotic symptoms; 6A70.2 for single episode, moderate, with psychotic symptoms).

ICD-11 codes for disorders with more complicated systems for specifiers might require the use of a sixth character. For example, the fifth character for acute and transient psychotic disorder indicates whether it is the first episode (6A23.0) or one of multiple episodes (6A23.1). Indicating whether it is currently symptomatic or in remission requires a sixth character. That is, 6A23.0 indicates acute and transient psychotic disorder, first episode; 6A23.00 is currently symptomatic. 6A23.01 is currently in partial remission; and 6A23.02 is currently in full remission.

ICD-11 refers to this method of providing unique codes for all possible combinations of first or multiple episodes and currently symptomatic or partial remission or full remission for acute and transient psychotic disorder as "pre-coordination." *ICD-11* offers a coding convention that allows additional codes to be linked to the initial diagnostic code, indicating other clinically significant features.

One type of post-coordination used in the chapter on mental, behavioral, and neurodevelopmental disorders involves appending codes that indicate specific symptomatic or course presentations that apply only to diagnoses within a particular diagnostic grouping. These include symptomatic manifestations of primary psychotic disorders; symptomatic and course presentations for mood episodes in mood disorders; prominent personality traits or patterns in personality disorders; and behavioral or psychological disturbances in dementia.

Diagnostic Categories

- *ICD-11* adds new diagnostic categories, such as catatonia, body dysmorphic disorder, and hoarding disorder
- *ICD-11* changes diagnostic criteria for existing diagnoses
- *ICD-11* omits a separate grouping for mental and behavioral disorders that begin in childhood and adolescence
- *ICD-11* groups mental and behavioral disorders to highlight developmental continuity across the lifespan

Assessment Measures

The WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) is a self-administered, 36-item rating scale that assesses six domains of functioning: understanding and communicating, getting around, self-care, getting along with people, life activities, and participation in society (APA, 2022, p. 854). There is a proxy-rated version of the instrument for those individuals who are unable to complete the scale independently. Scoring of the WHODAS 2.0 scale ranges from none (1), mild (2), and moderate (3) to severe (4) or extreme (5), with a total possible score of 180. A more complex scoring referred to as Item Response Theory (IRT) is done by computer and differentially rates items and levels of severity.

Differences between *DSM-5-TR* and *ICD-11*

This table summarizes important differences between *DSM-5-TR* and *ICD-11* (First et al., 2021; Gomez et al., 2023).

***DSM* Categorical Approach**	***ICD* Dimensional Approach**
• **Distinct Categories** *DSM* defines specific mental disorders as separate and distinct categories, such as depression, anxiety, or schizophrenia.	• **Continuum of Severity** *ICD* views mental disorders as existing on a spectrum or continuum, with varying levels of severity and intensity.
• **Binary Decision** A clinician determines if an individual meets the criteria for a specific disorder, essentially making a "yes" or "no" decision.	• **Graded Severity** Instead of a "yes" or "no" decision, *ICD* allows for a more nuanced assessment of the severity of a disorder.

• **No Gradation** Generally, other than a few exceptions, there's no allowance for degrees of severity or variations within a disorder.	• **Emphasis on Individual Differences** The dimensional approach acknowledges that individuals may experience different combinations and levels of symptoms and that there's a range of normal to pathological behaviors.
• **Exclusionary Criteria** *DSM* uses exclusionary criteria: A diagnosis is made only if the symptoms are not better explained by another disorder.	• **Focus on Traits** *ICD-11*, for example, includes a dimensional approach to personality disorders, focusing on broad trait domains and specific facets.

According to First et al. (2021), four diagnoses differ significantly in *DSM-5* when compared with *ICD-11*: severe childhood irritability and anger, compulsive sexual behavior disorder, personality disorders, and substance use disorders/substance dependence.

DSM-5 classifies severe childhood irritability and anger as disruptive mood dysregulation disorder, while *ICD-11* classifies it as oppositional defiant disorder with chronic irritability.

Although compulsive sexual behavior disorder was classified as hypersexual disorder and modeled after substance dependence in previous *DSM* versions, *DSM-5* does not include compulsive sexual behavior disorder at all; *ICD-11* classifies it as compulsive sexual behavior disorder (Feinstein et al, 2023).

DSM-5 retains general personality disorder criteria and 10 specific personality disorder categories that remain unchanged from *DSM-IV*. *ICD-11* implemented a dimensional model for personality disorders, incorporating assessments of general personality disorder diagnostic requirements, severity, and personality trait domains, followed by an assignment of Borderline Qualifier (if applicable).

Although substance use disorder/substance dependence had similar diagnoses in *DSM-IV* and *ICD-10, DSM-5* introduced a more dimensional approach, incorporating seven *DSM-IV* dependence items, three *DSM-IV* abuse items (minus substance-related legal problems), one new item (craving), and levels of severity from mild to severe. *ICD-11* retained the *ICD-10* categories of substance dependence and harmful use.

DSM is like a checklist, while *ICD* is like a sliding scale. *DSM* focuses on whether an individual meets the criteria for a specific disorder, while *ICD* focuses on the degree or severity of various traits and symptoms. According to the APA, *DSM-5* has introduced elements of a dimensional approach to some diagnoses, acknowledging the limitations of the purely categorical model.

Prolonged Grief Disorder

In March 2022, prolonged grief disorder (PGD) was added as a mental disorder in *DSM-5-TR* with diagnostic code F43.8. PGD is also in *ICD-11* under code 6B42. The primary difference between how *ICD-11* and *DSM-5-TR* diagnose PGD is that *ICD-11* requires only one core symptom of persistent longing or preoccupation with the deceased, alongside any of several additional symptoms, for a diagnosis. In contrast, *DSM-5-TR* requires a specific number of additional symptoms (at least three) to meet the diagnostic criteria. It also specifies a longer timeframe since the loss for a diagnosis to be made (12 months in *DSM-5-TR* versus six months in *ICD-11*); both systems still require significant functional impairment related to the grief symptoms.

Personality Disorder

ICD-11 uses a global evaluation of personality functioning to diagnose personality disorders rather than counting the number of criteria met. *ICD-11* categorizes personality disorders into five severity levels. *ICD-11* employs a dimensional model for personality disorders, whereas the *DSM-5-TR* utilizes general criteria and specific categories. There are no updates about the use of personality disorders as a diagnosis for individuals with IDD. Unlike previous versions, *ICD-11* does not have separate categories for different personality disorders; instead, it focuses on a single "personality disorder" diagnosis with severity levels. In *ICD*, the dimensional approach to diagnosing personality disorder means assessing the severity of a person's personality dysfunction along a continuum, rather than simply classifying the person into distinct categories of personality disorder. Essentially, the focus is on the degree of impairment caused by personality traits, with diagnoses like "mild," "moderate," or "severe" personality disorder, rather than specific personality disorder types like "borderline" or "narcissistic."

Substance Use Disorders

DSM-5-TR uses a more categorical approach to substance use disorders, while *ICD-11* uses a dimensional approach to substance dependence and harmful use. *ICD-11* considers a range of factors, including craving, levels of severity, and other diagnostic information. This approach gives clinicians more flexibility in assessing a condition's severity. *DSM-5-TR* uses more traditional diagnostic categories, such as substance dependence and harmful use. *ICD-11*'s dimensional approach can help clinicians identify additional areas of inquiry that may guide treatment and prognosis.

Secondary Mental Syndromes

ICD-11 groups secondary mental syndromes (i.e., secondary to medical conditions) together under a single category, whereas *DSM-5-TR* distributes them to other diagnostic groupings. As an example, someone with depression associated with a thyroid condition would be documented as having "major depressive disorder" utilizing *DSM-5-TR*, with a notation indicating that the depression is likely secondary to the thyroid condition. Utilizing *ICD-11* would give priority to the person's medical condition (thyroid condition) while noting there was accompanying depression. *ICD-11* prioritizes the underlying medical cause, whereas *DSM-5-TR* prioritizes the clinical presentation. There are similar differences in diagnosing ADHD. *DSM-5-TR* has nine inattention (IA) and nine hyperactivity/ impulsivity (HY/IM) symptoms, whereas *ICD-11* has 11 IA and 11 HY/IM symptoms (but 10 if "fidgeting" in children and "mental restlessness" in adults are combined as one). For further information, Gomez et al. (2023) provide an excellent summary.

Autism Spectrum Disorder

ICD-11 includes several innovations for diagnosing autism spectrum disorder (ASD), including:

Dimensional descriptions	*ICD-11* describes ASD as a continuum rather than using traditional categories.
Atypical sensory processing	*ICD-11* includes atypical responses to sensory stimuli as a diagnostic requirement. Atypical responses to sensory stimuli are included as part of the diagnostic requirements in *ICD-11*, in contrast to *ICD-10*, where unusual sensory processing was not yet considered a core (diagnostic) feature.
Social challenges	*ICD-11* recognizes that some individuals with ASD start to experience distress, impairment, and overt social challenges once societal demands increase (e.g., during adolescence or adulthood).
Intellectual disability	*ICD-11* provides guidelines for distinguishing between ASD with and without an intellectual disability. Unlike *DSM-5, ICD-11* does not emphasize the criteria related to disorders of intellectual development, such as flipping objects, strong attachment or preoccupation with unusual objects, excessive smelling or touching of objects, echolalia, or stimming.
Loss of acquired competencies	*ICD-11* considers loss of previously acquired competencies when making a diagnosis.
Play	*ICD-11* places less emphasis on the type of play in which children engage.
Severity rating	*DSM-5-TR* includes a severity level specifier for ASD, indicating the level of support needed, whereas *ICD-11* does not have a distinct severity level but considers functional impact within the diagnosis.

Developmental emphasis	*ICD-11* emphasizes the developmental nature of autism, recognizing that symptoms may not fully manifest until social demands exceed a person's capabilities, while *DSM-5-TR* focuses on symptoms present in early childhood.
Flexibility in interpretation	*ICD-11* provides more flexibility in interpreting symptoms, allowing clinicians to consider a wider range of presentations without strict symptom counts, whereas *DSM-5-TR* has more defined criteria.
Intellectual consideration	Both systems acknowledge the co-occurrence of autism and intellectual disability, but *ICD-11* specifically allows for separate diagnoses of autism with and without intellectual disability. *DSM-5* does not explicitly differentiate them.

While both *DSM-5-TR* and *ICD-11* classify autism as ASD, the key difference lies in how they approach the diagnosis. *ICD-11* places more emphasis on the developmental aspect of autism and allows for greater flexibility in interpreting symptoms, whereas *DSM-5-TR* focuses on more defined criteria for social communication deficits and repetitive behaviors, including severity levels based on functional impact. *ICD-11* does not have a separate severity rating system.

The ASD Criterion A phrase “as manifested by the following” was revised to read “as manifested by all of the following” to improve its clarity. The revision was made to maintain a high diagnostic threshold by requiring “all of the following” and not “any of the following” criteria, as could be mistakenly implied by the previous wording of the criterion.

ASD is listed in the *ICD-11* under the code 6A02. It falls within the category of neurodevelopmental disorders. This condition is characterized by persistent deficits in social communication and interaction and restricted, repetitive patterns of behavior, interests, or activities. Symptoms typically emerge during early childhood but may become more apparent as social demands increase.

Social Pragmatic Communication Disorder

The key difference between *DSM-5-TR* and *ICD-11* regarding social pragmatic communication disorder (SPCD) is that *DSM-5-TR* explicitly recognizes SPCD as a separate diagnostic category (place code), while *ICD-11* does not, instead classifying individuals with pragmatic language difficulties under a broader “developmental language disorder with impairment of mainly pragmatic language” category, meaning it does not have a distinct SPCD diagnosis. Both systems, however, recognize the importance of social communication impairments in diagnosis. Both systems emphasize difficulties with social communication skills like understanding nonverbal cues, taking turns in conversation, and adapting language to different social contexts.

As a result of differences between *DSM-5-TR* and *ICD-11*, clinicians using *ICD-11* for diagnosis may need to specify the nature of the pragmatic language difficulties in greater detail when documenting that diagnosis.

Fetal Alcohol Spectrum Disorders

IDD is listed under *ICD-11* with the code 6A00. It falls under the category of neurodevelopmental disorders. This condition is characterized by significantly below-average intellectual functioning and adaptive behavior, typically originating during the developmental period. The classification includes subcategories for varying levels of severity, such as mild (6A00.0), moderate (6A00.1), severe (6A00.2), and profound (6A00.3).

ICD-11 lists fetal alcohol syndrome (FAS) as a specific diagnosis within the broader category of fetal alcohol spectrum disorders (FASD). A total of five disorders compose fetal alcohol spectrum disorders. They are fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related neurodevelopmental disorder (ARND), a neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE), and alcohol-related birth defects (ARBD). All of these fetal alcohol spectrum disorders are used to classify the wide-ranging physical and neurological effects that prenatal alcohol exposure can have on a fetus.

Fetal Alcohol Syndrome (FAS)
Fetal alcohol syndrome (FAS) represents the most severe end of the FASD spectrum. FAS is listed as LD2F.00 in *ICD-11* because it's a specific malformation syndrome caused by maternal alcohol consumption during pregnancy. This code within *ICD-11* specifically describes FAS and its associated characteristics, including growth deficiency, facial anomalies, and central nervous system abnormalities. The code reflects the understanding that FAS is a unique clinical entity within the broader spectrum of fetal alcohol spectrum disorders (FASD).

People with FAS have central nervous system (CNS) problems, minor changes to facial features, and growth problems. People with FAS can have problems with learning, memory, attention span, communication, vision, or hearing. They might have a mix of these problems. People with FAS often have a hard time in school and trouble getting along with others.

Partial Fetal Alcohol Syndrome (pFAS)
When a person does not meet the full diagnostic criteria for FAS but has a history of prenatal alcohol exposure and some of the facial features, as well as a growth problem or CNS abnormalities, the person is considered to have pFAS.

Alcohol-related Neurodevelopmental Disorder (ARND)
People with ARND might have intellectual disabilities and problems with behavior and learning. They might do poorly in school and have difficulties with math, memory, attention, judgment, and poor impulse control.

Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE)
A child or youth with ND-PAE will have problems in three areas: (1) thinking and memory, where the child may have trouble planning or may forget material he or she has already learned, (2) behavior problems, such as severe tantrums, mood issues (for example, irritability), and difficulty shifting attention from one task to another, and (3) trouble with day-to-day living, which can include problems with bathing, dressing for the weather, and playing with other children. In addition, to be diagnosed with ND-PAE, the mother of the child must have consumed more than minimal levels of alcohol before the child's birth.

Alcohol-related Birth Defects (ARBD)
People with ARBD might have problems with the heart, kidneys, bones, or hearing. They might have a mix of these.

Clinical Descriptions and Diagnostic Requirements (CDDR)

ICD-11's Clinical Descriptions and Diagnostic Requirements (CDDR) was added to *ICD-11* in March 2024 to support a diagnosis of mental, behavioral, and neurodevelopmental disorders.

The new diagnostic guidance, reflecting the updates to *ICD-11*, includes the following features:

- Guidance on diagnosis for several new categories added in *ICD-11*, including complex post-traumatic stress disorder, gaming disorder, and prolonged grief disorder. This enables improved support to health professionals to better recognize distinct clinical features of these disorders, which may previously have been undiagnosed and untreated.
- Adoption of a lifespan approach to mental, behavioral, and neurological disorders, including attention to how disorders appear in childhood, adolescence, and older adulthood.
- Provision of culture-related guidance for each disorder, including how disorder presentations may differ systematically by cultural background.
- Incorporation of dimensional approaches (for example, in personality disorders), recognizing that many symptoms and disorders exist on a continuum with typical functioning.

The *ICD-11 CDDR* is aimed at mental health professionals and qualified nonspecialist health professionals, such as primary care physicians, responsible for assigning these diagnoses in clinical settings. It is also aimed at other health professionals in clinical and nonclinical roles, such as nurses, occupational therapists, and social workers, who need to understand the nature and symptoms of mental, behavioral, and neurodevelopmental disorders even if they do not personally assign diagnoses. The *ICD-11 CDDR* was developed and field-tested through a rigorous, multidisciplinary, and participatory approach involving hundreds of experts and thousands of clinicians from around the world.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Feinstein, J. A., Gill, P. J., & Anderson, B. R. (2023). Preparing for the *International Classification of Diseases, 11th Revision (ICD-11)* in the U.S. health care system. *JAMA Health Forum, 4*(7), e232253. https://doi.org/10.1001/jamahealthforum.2023.2253

First, M. B., Gaebel, W., Maj, M., Stein, D. J., Kogan, C. S., Saunders, J. B., Poznyak, V. B., Gureje, O., Lewis-Fernández, R., Maercker, A., Brewin, C. R., Cloitre, M., Claudino, A., Pike, K. M., Baird, G., Skuse, D., Krueger, R. B., Briken, P., Burke, J. D., Lochman, J. E., Evans, S. C., Woods, D. W., & Reed, G. M. (2021). An organization- and category-level comparison of diagnostic requirements for mental disorders in ICD-11 and DSM-5. *World Psychiatry, 20*(1), 34–51. https://doi.org/10.1002/wps.20825

Gomez, R., Chen, W., & Houghton, S. (2023). Differences between DSM-5-TR and ICD-11 revisions of attention deficit/hyperactivity disorder: A commentary on implications and opportunities. *World Journal of Psychiatry, 13*(5), 138–143. https://doi.org/10.5498/wjp.v13.i5.138

World Health Organization. (2022). *ICD-11: International classification of diseases* (11th revision). https://icd.who.int/

World Health Organization. (2024). *Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders (ICD-11 CDDR)*. https://www.who.int/publications/i/item/9789240077263