03 - Introduction

01 - A brief history of the CDDR

A brief history of the CDDR

02 - Intended users of the CDDR

Intended users of the CDDR

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders A brief history of the CDDR ICD-6 (9) was the first version of the classification published by WHO, the first to contain a classification of morbidity as well as mortality, and the first to include a classification of mental disorders. In both ICD-6 and ICD-7 (10), the only information provided for mental disorders was the code number and name for each diagnostic category, along with inclusion terms, which specified some of the range of diagnostic concepts meant to be encompassed by the category. Starting with ICD-8 (11), the WHO Department of Mental Health and Substance Use began to provide additional information to assist with clinical implementation. In 1974, the Department published a glossary of mental disorder terms and additional guidance related to the classification of mental disorders (12), indicating that “unless some attempt is made to encourage uniformity of usage of descriptive and diagnostic terms, very little meaning can be attributed to the diagnostic side of statistics of mental illness based on the ICD and in many other ways communication between psychiatrists will become increasingly difficult” (12, p. 12). Subsequently, brief definitions were also included in the main, statistical version of the classification for all categories in the mental disorders chapter in ICD-9 (13) and ICD-10 (14). (This innovation in the classification of mental disorders in ICD-9 and ICD-10 has now been applied across the entire ICD-11 so that the MMS contain brief descriptions for most categories in the classification.) However, according to the WHO Department of Mental Health and Substance Use, these brief definitions were not recommended for use by mental health professionals but rather were intended for use in health statistics and in the coding of medical records and death certificates (15). In 1992, the Department published a volume entitled The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines (CDDG) (15) concurrently with the publication of the statistical version of ICD-10. The CDDG was “intended for general clinical, educational, and service use” (15, p. 1). For each disorder, a description of the main clinical and associated features was provided, followed by more operationalized diagnostic guidelines that were designed to assist mental health clinicians in making a valid diagnosis. The CDDR for ICD-11 represent an important advance in providing comprehensive practical guidance on diagnosing mental disorders. A major improvement in the ICD-11 CDDR compared to the ICD-10 CDDG is the consistency of structure and information across major categories, based on reviews of the available evidence (16). The development of the CDDR has been guided by the principles of clinical utility and global applicability. The information included is intended to be useful to health professionals in making diagnostic judgements about

individual patients, including the features they can expect to see in all cases of a given disorder and how to differentiate disorders from non-pathological expressions of human experience and from other disorders including medical conditions. The CDDR describe additional clinical features that may be present in some cases of a given disorder and provide key information that can assist in evaluating diagnoses across cultures, genders and the lifespan. More information about the specific contents and approach of the CDDR is provided in the next section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings. The reliability, clinical utility and global applicability of the CDDR have been confirmed through a comprehensive programme of developmental and evaluative field studies (6,17–19) that involved thousands of clinicians in all global regions. This research programme is described in more detail later in this chapter. Intended users of the CDDR The CDDR are designed to be used by mental health professionals who are authorized by training, scope of practice and applicable statute to provide diagnostic evaluations of people with mental disorders (e.g. psychiatrists, psychologists in some countries). They are also intended to

03 - Development of the MMS and the CDDR for ICD 1

Development of the MMS and the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders

3 be useful to non-specialist health professionals (e.g. primary care physicians, nurses), who in many countries provide a substantial proportion of total mental health services. They will also be useful for other professionals in clinical and non-clinical roles who need to understand the nature and symptoms of these disorders even if they do not personally diagnose them. Finally, the CDDR are intended to provide students and trainees in variety of mental health and other health fields with comprehensive guidance and information to support their development as competent diagnosticians or interdisciplinary team members. It is important to note that the organization of ICD-11 into chapters is not intended to reflect the scope of practice of specific medical specialties or clinical professions. For example, mental, behavioural and neurodevelopmental disorders and diseases of the nervous system are in separate chapters, but WHO does not intend this as a statement that psychiatrists should not be allowed to assess and treat headache disorders or that neuropsychologists should not be permitted to evaluate which disease process may be causing a particular case of dementia given the pattern of symptoms. Similarly, certain mental disorders (e.g. neurocognitive disorders such as dementia or delirium, or dissociative disorders such as dissociative neurological symptom disorder or dissociative amnesia), frequently come to the attention of a variety of health professionals (e.g. primary care physicians, neurologists) who may be equipped to evaluate and diagnose them using the CDDR as a guide. Health-care professionals using the CDDR to make diagnoses should be qualified to do so by their clinical training and

experience, and are expected to have the necessary clinical expertise and understanding of mental disorders to identify symptoms and to distinguish disorders from normal variation, from one another, and from transient responses to stress or environmental circumstances. The CDDR are written to allow for the exercise of clinical judgement, and it is the diagnosing health professional who is responsible for developing a diagnostic formulation appropriate for an individual patient, considering the patient's individual, social and cultural context as well as the characteristics of the health system. It is equally important to note that diagnostic classification is only a part of patient assessment. The CDDR are not a guide to patient care, nor a comprehensive textbook of psychiatry, nor a manual of how to conduct clinical assessments and differential diagnoses. The focus of the CDDR is on the classification of disorders and not the assessment and treatment of people, who are frequently characterized by multiple disorders and diverse needs (5). Development of the MMS and the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders As noted above, the WHO Department of Mental Health and Substance Use led the development of the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders, including both the MMS and the CDDR. Over the course of more than a decade, the Department coordinated an intensive, systematic, international process that involved a wide range of key stakeholder groups including scientific and public health experts, clinicians, representatives of WHO Member States, scientific and professional societies, service users and their carers, and other nongovernmental organizations. All expert contributors to this document were asked to complete a WHO Declaration of Interests (DoI) form prior to their contribution. Once received, the WHO Secretariat reviewed the DoI forms and evaluated whether there were any conflicts of interest and, if so, whether these required a management plan. Prior to the finalization of this document, all contributors were asked to complete another DOI form. No conflicts of interest requiring a management plan were identified. Introduction

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Formation of the ICD-11 International Advisory Group In 2007, the WHO Department of Mental Health and Substance Use appointed the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders (5), comprising scientific experts from all WHO regions and representatives from relevant international scientific societies. This Advisory Group was tasked with scientific oversight for the entire revision process. Its specific functions were to advise WHO on the key guiding principles and goals of the revision, the steps involved in the revision, and identification of other groups of relevant consultants and stakeholders required to develop the classification of mental disorders and other relevant parts of ICD-11; and to facilitate the implementation of global field studies to assess and improve the revisions to ICD-11 and the CDDR. The Advisory Group also functioned as one of approximately 30 topic advisory groups for the overall development of ICD-11, each focusing on a different area or cross-cutting theme (e.g. gastroenterology, ophthalmology, quality and safety) and represented on the Revision Steering Committee – working with the WHO Classifications and Terminology and Data Standards Team responsible for coordinating the overall effort. Development of the CDDR by ICD-11 working groups The International Advisory Group advised the WHO Department of Mental Health and Substance Use on the appointment of more than a dozen working groups tasked with reviewing the relevant evidence and making proposals for changes to the structure and content of the ICD-10 classification of mental, behavioural and neurodevelopmental disorders. Most of the working groups were established in relation to a particular subset of mental disorders (e.g. psychotic disorders, mood and anxiety disorders, personality disorders). Others were appointed to make

proposals regarding how cross-cutting themes (e.g. presentations in children and adolescents, presentations in older adults, cultural factors) would be handled in the CDDR. Members of the working groups were expert multidisciplinary mental health professionals with relevant scientific and/or clinical expertise. The working groups were constituted such that experts from all WHO regions were included, with substantial representation from low- and middle-income countries. The working groups' charge included reviewing the extant body of basic science, clinical and public health research relevant to their area of responsibility for use as a basis for their recommendations for revisions to the classification of mental disorders in ICD-10. The working groups used these reviews to recommend changes to enhance the validity of ICD-11 (e.g. addition or deletion of categories, changes in thresholds or diagnostic requirements). They also reviewed available evidence related to the clinical utility of proposed changes, such as whether the revised diagnostic descriptions would enhance the identification of individuals who need mental health services or their usefulness in treatment and management decisions in a range of global health-care settings, particularly in low- and middle-income countries. Working groups proposed specific changes to the structure of the classification of mental disorders in ICD-11; what categories and specifiers were included; and the MMS brief descriptions and the CDDR for the area under their purview. They were asked to provide the rationale, evidence base and expected impact on clinical utility of any proposed change via a structured, documented process (16). Working groups were instructed to emphasize considerations of clinical utility and global applicability in developing their recommendations. Clinical utility is important because health classifications represent the interface between health encounters and health information. A system that does not provide clinically useful information at the level of the health encounter will not be faithfully implemented by clinicians. In that case, data aggregated from health encounters will not be optimal and perhaps not even valid, affecting the usefulness and validity of summary health encounter data used for decision-making at the health system, national and global level. The WHO Department of Mental Health and Substance Use operationalized the clinical utility

5 of a category in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders as depending on: • its value in communicating (e.g. among practitioners, patients, families, administrators); • its implementation characteristics in clinical practice, including its goodness of fit (i.e. accuracy of description), its ease of use and the time required to use it (i.e. feasibility); • and its usefulness in selecting interventions and in making clinical management decisions. Global applicability was addressed via the diverse global membership of the working groups and by the international nature of the field studies implemented as part of the development of the CDDR, and by specific attention to culture as a part of the CDDR (see the sections on public review and field testing and on cultural factors below). In order to generate relatively uniform information and a consistent structure across groupings and categories of the CDDR (see the next section on using the ICD-11 classification of mental, behavioural and neurodevelopmental disorders in clinical settings), working groups collated diagnostic information using a standardized template (referred to as a "content form"), with relevant references. This information served as source material for the development of the CDDR, with the final editorial responsibility vested in the WHO Department of Mental Health and Substance Use. The brief descriptions in the MMS and the more detailed essential features in the CDDR were developed together in order to be fully compatible, though designed for different purposes. The MMS brief descriptions are typically summaries of the essential features for the corresponding entity in the CDDR, although these brief descriptions alone do not provide sufficient information for implementation in clinical settings. Public review and field

testing Proposals developed by working groups were described in the scientific literature (e.g. 20–26), made available for public review (27), and tested via a systematic programme of global field studies (see the section on field studies below). Scientific oversight for the field studies was provided by the ICD-11 Field Studies Coordination Group (FSCG) (28), comprising global leaders in clinical care, scientific research and public health representing all WHO regions, with substantial representation from low- and middle-income countries. FSCG members not only lent their technical expertise to the design, analysis and interpretation of the field studies but also served as essential facilitators by successfully engaging global clinicians to participate in ICD-11 field studies around the world. Many of them directed international field study centres, which conducted field studies in routine clinical settings with real patients. The FSCG and relevant working groups were also involved in proposing changes to the CDDR based on the results of the field studies (17). WHO's comprehensive programme of field testing to assess the reliability, clinical utility and global applicability of the proposed CDDR was a major area of innovation, employing novel study designs and new methodologies for collecting information. Global participation was a defining characteristic of the ICD-11 CDDR field studies, which engaged multidisciplinary clinicians working in diverse contexts across the world, and were conducted in multiple languages. A key strength of the research programme was that studies were conducted within a time frame that allowed the results to be used as a basis for further revision of the CDDR prior to publication. Early in the revision process, two major international, multilingual surveys were conducted – one of psychiatrists, conducted in collaboration with the World Psychiatric Association (29) and the other of psychologists, conducted in collaboration with the International Union of Psychological Science (30). These surveys focused on participants' use of diagnostic classification systems in clinical practice, and the desirable characteristics of a classification of mental disorders. The professionals overwhelmingly preferred more flexible guidance to allow for cultural variation Introduction

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders and clinical judgement compared to a strict criteria-based approach, and were receptive to a system incorporating a dimensional component. Respondents described a number of categories as having poor clinical utility in practice, while others were recommended for addition or deletion (31,32). These data were used in the initial decisions about the content of the CDDR and in the development of diagnostic guidance by working groups. In order to provide data to assist in developing an organizational structure that would be more clinically useful, two formative field studies were conducted to examine the conceptualizations held by mental health professionals around the world regarding the structure of mental disorders and the relationships among them (33,34). These data showed a high degree of similarity across countries, languages and regions, regardless of the classification system participants used in clinical practice, and informed decisions about the structure of the classification. The proposed CDDR material was then tested in two main sets of evaluative field studies: case-controlled (internet-based) and ecological implementation (clinic-based) field studies. The case-controlled studies assessed the clinical utility of the proposed diagnostic material; most compared how global clinicians applied the proposed ICD-11 material versus the ICD-10 diagnostic guidelines for a given diagnostic area in terms of accuracy and consistency of clinicians' diagnostic formulations, using a scientifically rigorous vignette-based methodology (17,35). Other studies examined scaling for diagnostic specifiers (36) and how clinicians actually used classifications in their clinical practice (37), including how they combined multiple dimensions in making a categorical diagnosis (38). Case-controlled studies were conducted in between three and six languages – Chinese, English,

French, Japanese, Spanish and Russian – per study, with participation from thousands of clinicians from across the globe who were members of WHO's Global Clinical Practice Network. The Network's field studies have assessed a wide range of disorder groupings (e.g. 39–45). Two internet-based studies comparing ICD-11 to ICD-10 were also conducted in German (46,47). Overall, these studies have demonstrated incrementally superior – or in some cases equivalent – performance of the ICD-11 CDDR compared to the ICD-10 CDDG in the accuracy of diagnoses assigned to case vignettes by participating clinicians, as well as improvements in ratings of clinical utility. When a clinician's diagnoses did not follow the expected pattern, the study methodology allowed for examination of which specific features of the diagnostic requirements accounted for underperformance, which in turn permitted modifications to the CDDR to address points of ambiguity or misunderstanding (e.g. 39,44). These studies also included analyses of results by region and language to identify potential difficulties in global or cultural applicability, as well as problems in translation. In addition to refining the CDDR, data from these studies have provided useful information for the development of training programmes on the new ICD-11 diagnostic material. For example, the German study examining performance on a coding task suggested a substantial need for training initiatives to support the use of ICD-11 by professional coders (47). Two major ecological implementation (clinic-based) field studies were conducted. The first tested the proposed CDDR diagnostic material when applied by practising clinicians to adult patients receiving care in the types of clinical settings in which the CDDR will be implemented (18,19). The study was conducted in 14 countries – Brazil, Canada, China, Egypt, India, Italy, Japan, Lebanon, Mexico, Nigeria, the Russian Federation, South Africa, Spain and Tunisia – via a network of international field study centres. The study assessed the reliability and clinical utility of the CDDR for disorders that account for the highest percentage of global disease burden and use of mental health services in clinical settings among adults: schizophrenia and other psychotic disorders, mood disorders, anxiety and fear-related disorders, and disorders specifically associated with stress. A joint-rater reliability methodology, in which two clinicians were present during the patient interview but reported their diagnostic formulation and clinical utility ratings

7 independently, was employed in order to isolate the effects of the CDDR from other sources of variance in diagnosis (e.g. changes over time, inconstancy in reporting). Importantly, the level of training on the ICD-11 CDDR received by participating clinicians was similar to what might be expected in routine clinical setting during ICD-11 implementation. Clinicians were given no instructions on how to conduct their diagnostic interviews other than to assess the areas that were required as part of the study protocol. Overall, intraclass kappa coefficients (a measure of reliability between raters) for diagnoses weighted by site and study prevalence ranged from 0.45 (dysthymic disorder) to 0.88 (social anxiety disorder). The reliability of the ICD-11 diagnostic requirements was superior to that previously reported for equivalent ICD-10 guidelines (18). Clinician ratings of the clinical utility of the ICD-11 CDDR were very positive overall. The CDDR were perceived as easy to use, accurately reflecting patients' presentations (i.e. goodness of fit), clear and understandable, and no more time-consuming than the clinicians' standard practice (19). A separate study of common child and adolescent diagnoses was conducted in four countries – China, India, Japan and Mexico – with children and adolescents from 6 to 18 years of age (48). The study focused on attention deficit hyperactivity disorder, disruptive behaviour and dissocial disorders, mood disorders, anxiety and fear-related disorders, and disorders specifically associated with stress, using a design that was analogous to the adult study. Kappa estimates indicated substantial agreement for most categories, with moderate agreement for generalized anxiety disorder and

adjustment disorder. No differences were found between younger (6–11 years) and older (12–18 years) age groups, or between outpatient and inpatient samples. Clinical utility ratings for these diagnoses were positive and consistent across the domains assessed, although they were somewhat lower for adjustment disorder. Taken together, the results of the ecological implementation studies supported the implementation of the ICD-11 CDDR in clinical settings, and suggested that the results of the case-controlled studies were generalizable to clinical settings. Another clinic-based field study in three countries examining the novel behavioural indicators for the assessment of the severity of ICD-11 disorders of intellectual development found them to have good to excellent levels of inter-rater reliability, concurrent validity and clinical utility. This supported their use to assist in the accurate identification of individuals with disorders of intellectual development, particularly in settings where specialized assessment services are unavailable (49). A separate field studies programme to test the section of the ICD-11 CDDR on disorders due to substance use and addictive behaviours involved field testing centres in 11 countries: Australia, Brazil, China, France, Indonesia, India, the Islamic Republic of Iran, Malaysia, Mexico, Switzerland and Thailand. The main aim of the studies was to explore the public health and clinical utility, feasibility and stability (comparability with ICD-10) of the proposed CDDR for disorders due to the use of psychoactive substances, as well as the newly designated subgrouping of disorders due to addictive behaviours (i.e. gambling disorder and gaming disorder). The mixed-methods approach used in these studies included key informant surveys and interviews, focus groups and consensus conferences at each study site. Across sites, more than 1000 health professionals participated in the survey, more than 200 participants were involved in 30 focus groups organized at the study sites, and 42 identified national experts in the field reviewed the draft CDDR. Overall, this section of ICD-11 was judged to be major step forward compared to ICD-10 in terms of its utility for meeting clinical and public health, and its feasibility for implementation. There was broad support for major innovations in this area. For disorders due to substance use, this included the expansion of substance classes to reflect evolving patterns in global psychoactive substance use (e.g. synthetic cannabinoids, MDMA1 or related drugs), the introduction of new categories to capture episodes of harmful substance use, and the inclusion of the concept of “harm to health of others” in the definition of harmful substance use (25). There was also support for 3,4-methylenedioxy-methamfetamine, also known as “ecstasy”. Introduction

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders integrating disorders due to addictive behaviour in the same overarching grouping as disorders due to substance use, and for the introduction of the new diagnostic category gaming disorder. At the same time, the field study results highlighted the overall increase in complexity of this part of ICD-11 and the need for training of health professionals in order to ensure a smooth transition. The field studies also yielded specific suggestions for better delineation of the boundaries among some diagnostic categories as well as better descriptions of new ones. In addition, WHO commissioned a study (50) on the concordance among diagnoses for alcohol and cannabis use disorders based on ICD-11, ICD-10 and the Diagnostic and Statistical Manual of Mental Disorders, fourth and fifth editions (DSM-IV and DSM-5) (51,52). The results of the study demonstrated high concordance among the populations identified by the ICD-11 diagnostic requirements compared to ICD-10 and DSM-IV. Concordance of between ICD-11 and DSM-5 was substantially lower, in large part due to low agreement between the diagnoses of harmful pattern of alcohol use and harmful pattern of cannabis use in ICD-11 and mild alcohol use disorder and mild cannabis use disorder in DSM-5. Development of the CDDR also

included the involvement of mental health service users and carers through two studies in 15 countries representing diverse clinical contexts in multiple global regions (53,54). These studies constituted the first instance of a systematic research programme studying mental health service users' perspectives during the revision of a major diagnostic classification system. The studies employed participatory research methodologies to systematically collate service user perspectives on key CDDR diagnoses that contribute to high disease burden, including schizophrenia, depressive episode, bipolar type I disorder, generalized anxiety disorder and personality disorder. Findings from these studies provided an understanding of how mental health service users respond to diagnostic content of the CDDR, and served as a basis for providing recommendations to WHO about potential enhancements of CDDR diagnostic material that may enhance its clinical utility (e.g. its usefulness in communicating with service users) and mitigating potential unintended negative consequences of the diagnostic material, including stigmatization of diagnosed individuals. Coordination with the development of DSM-5 The development of ICD-11 overlapped with the development and publication of DSM-5 (52). The Chair and Co-Chair of the DSM-5 Task Force regularly attended meetings of the Advisory Group in an effort to facilitate "harmonization" of the two classifications. This was most successful in terms of the way that mental disorders are divided into groupings and how those groupings are ordered in the two classifications (referred to as the "metastructure"). In this regard, ICD-11 and DSM-5 are quite similar to one another, though not identical, and substantially different from ICD10 and DSM-IV. Most ICD-11 working groups included at least one member of the corresponding DSM-5 workgroup. ICD-11 working groups were asked to consider the clinical utility and global applicability of material being developed for DSM-5, with the goal of minimizing unintentional or arbitrary differences between the two systems. Intentional conceptual differences were permitted, however, and the working groups were asked to provide a justification for such differences where they were proposed. The differences between ICD-11 (both the MMS and the CDDR) and DSM-5 are therefore conscious and intentional (16,55), and a number of such differences have stimulated valuable research that has enhanced our knowledge about psychopathology (56).

04 - Key approaches to classifying mental, behavio

Key approaches to classifying mental, behavioural and neurodevelopmental disorders

9 Key approaches to classifying mental, behavioural and neurodevelopmental disorders The definition of mental, behavioural and neurodevelopmental disorders The ICD-11 chapter on mental, behavioural and neurodevelopmental disorders begins with the following definition: Mental, behavioural and neurodevelopmental disorders are syndromes characterized by clinically significant disturbance in an individual’s cognition, emotional regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning. The term “disorder” is used as a part of nearly all category titles in the chapter. Although “disorder” is not a precise term, as in ICD-10 its use is intended “to avoid even greater problems inherent in the use of terms such as ‘disease’” (15, p. 11), which implies greater certainty about etiology and pathophysiology than exists for most mental disorders. Although mental disorders are by definition syndromes, “syndrome” is a broader term with more variable usage. Its use in category titles in the classification of mental, behavioural and neurodevelopmental disorders is restricted to the grouping of secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere; these are conditions with more variable symptoms that are less specified in the CDDR, but are judged to be direct pathophysiological consequences of a medical condition. Other conditions referred to as syndromes that are mentioned in the CDDR are classified in other

parts of ICD-11 (e.g. Tourette syndrome is included in the chapter on diseases of the nervous system). Beyond the issue of terminology, the definition of mental, behavioural and neurodevelopmental disorders helps to delineate two boundaries. The first is the boundary between mental, behavioural and neurodevelopmental disorders and diseases and disorders classified in other chapters of ICD-11, and the second is the boundary between mental, behavioural and neurodevelopmental disorders and normality. Both of these boundaries represent key issues in diagnosis. The first part of the definition ("clinically significant disturbance in an individual's cognition, emotional regulation or behaviour") indicates that the essential features of the disorders included in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders invariably involve (but are not limited to) symptoms from these domains of mental and behavioural functioning. The presentation of disorders in other ICD-11 chapters (e.g. those on diseases of the nervous system and sleep-wake disorders) may include disturbances in these domains, but they are not common to all the disorders in those chapters. The second part of the definition is intended to clarify that in order for a clinical presentation to be diagnosable as a mental, behavioural or neurodevelopmental disorder (as opposed to representing normal variation), the symptom must reflect a dysfunction in an underlying psychological, biological or developmental process. For example, the experiences of an individual who has recently been bereaved might include acute feelings of sadness and emptiness accompanied by disturbances in cognition, emotional regulation or behaviour. However, symptoms entirely attributable to grief are not in and of themselves indicative of an underlying dysfunction in a psychological, biological or developmental process. Normal bereavement is not considered to be a disorder, despite its potential negative impact on social and occupational functioning. Similarly, behaviour (e.g. political, religious, sexual) that deviates from the accepted standards of society is only considered to be symptomatic of a mental disorder if it is a manifestation of a dysfunction in a psychological, biological or developmental process. Introduction

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders The final part of the definition ("these disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning") notes that distress in the individual and/or impairment in functioning is commonly a consequence of the symptoms, and for many mental disorders is an essential feature. At the same time, it is not always required (e.g. individuals experiencing a hypomanic episode in the context of bipolar type II disorder often do not experience distress about their condition, and by definition do not exhibit functional impairment), hence the use of "usually" in the definition. Structure of the chapter on mental, behavioural and neurodevelopmental disorders The organization of the ICD-10 chapter on mental and behavioural disorders had been dictated in part by the ICD-10 coding system itself. The first character of ICD-10 codes, which indicated the chapter, was alphabetical, thus allowing for up to 26 chapters. The second character, which indicated the diagnostic grouping within the chapter, was numerical, effectively limiting the number of possible diagnostic groupings within a chapter to 10. The use of alphanumeric characters throughout the ICD-11 coding system removes those artificial constraints. Consequently, there are 21 diagnostic groupings in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders. A few of the ICD-11 diagnostic groupings are completely parallel to ICD-10 groupings (e.g. disorders due to substance use, schizophrenia and other primary psychotic disorders, mood disorders). Most of the other ICD-10 diagnostic groupings were split into multiple ICD-11 groupings. For example, ICD-10 neurotic, stress-related and somatoform disorders was split

into five ICD-11 diagnostic groupings: anxiety and fear-related disorders; obsessive-compulsive and related disorders; disorders specifically associated with stress; dissociative disorders; and bodily distress disorders. In one case, three ICD-10 diagnostic groupings (mental retardation; disorders of psychological development; and behavioural and emotional disorders with onset usually occurring in childhood and adolescence) were combined into a single neurodevelopmental disorders grouping in ICD-11, although some of the disorders that were included in the behavioural and emotional disorders with onset usually occurring in childhood and adolescence grouping in ICD-10 were placed into other ICD-11 diagnostic groupings based on symptomatic presentations (e.g. conduct disorders were placed in the disruptive behaviours or dissocial disorders grouping in ICD-11). Disorders of intellectual development in ICD-11 have been reconceptualized from ICD-10 mental retardation such that they are assessed based on adaptive behaviour functioning in addition to intellectual functioning. The elimination of ICD-10 diagnostic groupings explicitly linked to onset of the condition during childhood and adolescence is in part related to the decision to adopt a lifespan approach to the description of diagnostic categories in ICD-11. Each category contains a section on developmental presentations, which describes the manifestations of the disorder in early and middle childhood, adolescence and older adulthood, to the extent possible based on available evidence. The ICD-11 CDDR also include descriptions of adult presentations of most disorders described exclusively in terms of children in the ICD-10 CDDG (e.g. attention deficit hyperactivity disorder, separation anxiety disorder, conduct disorder, pica). Four diagnostic subgroupings were moved out of the mental, behavioural and neurodevelopmental disorders chapter entirely and placed within other ICD-11 chapters: ICD-10 nonorganic sleep disorders were moved to the ICD-11 chapter on sleep-wake disorders, ICD-10 sexual dysfunctions not caused by organic disorder or disease and gender identity disorders were moved to the ICD-11 chapter on conditions related to sexual health, and ICD-10 tic disorders were moved to the ICD-11 chapter on diseases of the nervous system. The movement of sleep-wake disorders and sexual dysfunctions to new, separate chapters in no way indicates that these conditions are

11 not appropriately treated by mental health professionals. Rather, it reflects an effort to remove the artificial and scientifically and clinically inaccurate “mind–body split” embodied in the designation of “organic” and “nonorganic” forms of these disorders. The inclusion of ICD-11 gender incongruence in the chapter on conditions related to sexual health reflects the conclusion that these conditions are not appropriately viewed as mental disorders based on a series of international field studies indicating that distress and functional impairment in transgender people is predicted by experiences of stigmatization and victimization rather than being an intrinsic characteristic of being transgender (57–59). Categories and dimensions ICD-10 was almost entirely categorical in nature (categories were either present or absent), with the only exceptions being severity-based subcategories for mental retardation (mild, moderate, severe, profound) and depressive episode (mild, moderate, severe). ICD-11 has moved beyond a strictly categorical approach, incorporating dimensional elements in two different ways. First, in addition to intellectual developmental disorder and depressive episode, bodily distress disorder, personality disorder and dementia are subcategorized based on severity (mild, moderate, severe). Second, a number of mental disorders allow for the indication of symptomatic manifestations that are intended to provide dimensional profiles that cut across different disorders in a particular grouping. These include symptomatic manifestations of primary psychotic disorders (positive symptoms, negative symptoms, depressive mood symptoms, manic mood symptoms, psychomotor symptoms, cognitive symptoms), which can be further coded as not present, mild, moderate or severe, and

prominent personality trait domains in personality disorders (negative affectivity, detachment, asociality, disinhibition, anankastia). See the following section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings for specific examples of how these dimensional specifiers are coded. Cultural factors Because the CDDR will be employed around the world as a basis for diagnosis and treatment selection among people living in diverse social milieus and cultural contexts, a key priority in development of the diagnostic material was to consider and reflect the influence of culture. Cultural factors affect the diagnosis of mental, behavioural and neurodevelopmental disorders in complex and multifaceted ways. For example, culture can influence how disorders are conceptualized, experienced and expressed; what is considered normal or pathological; how functioning is affected; where and how people seek care; and the ways that patients and families participate in treatment. Attention to culture was also in line with the overall priority of the revision process to enhance the clinical utility and global applicability of the CDDR. Information that makes the diagnostic system more relevant and acceptable to clinicians and service users around the world can enhance the usefulness of the CDDR as tool for identifying those who require care and connecting them to services. WHO appointed a Working Group on Cultural Considerations to develop material on culture for the CDDR. This Working Group conducted extensive consultations with experts from around the world, and systematically reviewed the literature on cultural influences on diagnosis and psychopathology for each diagnostic category, as well as relevant material on culture from ICD-10 and DSM-5. Information was also collated from materials produced by other ICD-11 working groups as part of their generation of proposed content for their respective diagnostic areas. On this basis, the Working Group developed a section entitled “culture-related features” for diagnostic categories in the CDDR. The focus was on providing pragmatic, actionable material to assist clinicians in using the CDDR to evaluate patients in a culturally informed manner and reduce bias in clinical decision-making. This section is meant to be of practical use in the process Introduction

05 - Using the CDDR in research

Using the CDDR in research

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders of engagement, diagnosis, evaluation and treatment selection, and addresses the following areas: • cultural variation in prevalence and symptoms of disorders; • information about social contexts and sociocultural mechanisms that may account for this variation; and • descriptions of cultural concepts of distress (e.g. idioms, causal explanations) that are relevant to diagnosis and treatment decisions, prioritizing cultural variations that may be associated with national or ethnocultural background (60,61). The resulting guidance aims to assist the clinician in making informed decisions likely to foster more contextually applicable patient-centred care that is sensitive to the cultural and social milieu of the clinical encounter. For example, the section on culture-related features of the CDDR for panic disorder indicates that the symptom presentation of panic attacks may vary across cultures, and describes several notable cultural concepts of distress that link panic, fear or anxiety to cultural attributions regarding specific social and environmental influences. Understanding these attributions can assist in differential diagnosis and can also clarify whether panic attacks should be considered expected or unexpected (as is required for a diagnosis of panic disorder) given the environmental circumstances. The development of the CDDR incorporated cultural considerations in several other ways. First, global applicability of diagnostic material was identified early on as an overarching objective of the CDDR, and the development process was led and guided by experts and clinicians representing all major global areas. The Advisory Group, the FSCG and all working groups included members with diverse geographical and linguistic backgrounds, many of whom had direct experience working in low-resource contexts and within various cultures. The design and implementation of ICD-11 field studies also adhered to the principle of enhancing the global and cultural applicability of the CDDR by engaging thousands of clinicians from around the world in a comprehensive research programme to assess the reliability, clinical utility and global applicability of the requirements. For example, the formative studies that helped to shape the architecture and linear structure of the CDDR involved clinicians from over 40 countries and were conducted in multiple languages. The evaluative case-controlled studies engaged clinicians in large-scale, multilingual studies related to major diagnostic areas of the CDDR. The clinicians who participated in the case-controlled studies were members of the Global Clinical Practice Network (62), which now includes more than 18 000 mental health professionals from over 160 countries, and was established by WHO for the purposes of assisting in the development of ICD-11 by its members participating in internet-based field studies. Similarly, clinic-based field studies testing the

implementation of the CDDR with real patients took place in over 25 study sites in 14 culturally, linguistically and geographically diverse countries. Hundreds of clinicians in these countries provided feedback directly on the CDDR to help enhance its reliability and utility in culturally diverse global settings. Using the CDDR in research In addition to the ICD-10 CDDG, the WHO Department of Mental Health and Substance Use published The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research (DCR) (63) as a companion document. The DCR presented fully operationalized criteria for ICD-10 mental disorder entities, specifically intended for use in research. These criteria were designed to replace the “diagnostic guidelines” portion of the corresponding category in the CDDG, which tended to be more flexible and less fully operationalized. The core criteriabased approach taken in the DCR was therefore much more compatible with the approach of

13 DSM-IV (51), although substantial differences between the two systems remained (64). However, almost no research using the ICD-10 DCR appears to have been published. The greater standardization and the provision of a broader and more systematic range of clinically relevant information in the ICD-11 CDDR compared to the ICD-10 CDDG (16) was designed to make the CDDR more useful in clinical decision-making, and therefore also in education and training. The extremely high ratings of the clinical utility of the CDDR, particularly in international clinic-based field studies with real patients (19,48) suggest that this objective was achieved. Moreover, the solid reliability results from the ICD-11 field studies (18,48) indicate that the CDDR would be satisfactory for use in certain kinds of research projects – for example, projects focused on individuals with particular diagnoses as these are assigned in health-care settings (e.g. patients diagnosed with recurrent depressive disorder receiving services at a particular facility). However, in other types of research projects, in which obtaining reproducible and precise psychiatric diagnoses is more important, standardized diagnostic assessment procedures are necessary. This is meant to control variability inherent in diagnostic processes that rely on the interviewer’s diagnostic interviewing skills (different interviewers may ask different questions to assess the same clinical phenomena) and clinical judgement (different interviewers may arrive at different diagnostic conclusions). For example, studies of the efficacy of treatments for particular disorders require consistency in diagnostic procedures to ensure that the population being studied has been assigned the diagnosis for which the treatment is intended according to consistent and explicit diagnostic rules to reduce random diagnostic heterogeneity. Similarly, epidemiological studies that utilize lay (i.e. not clinically trained) interviewers to apply the ICD-11 CDDR require pre-scripted questions and strict decision rules because they cannot rely on the clinical expertise of the interviewer to make judgements about which features are present. For these reasons, several WHO-sponsored diagnostic instruments are being developed to facilitate the application of the ICD-11 CDDR in particular research settings. The Structured Clinical Interview for ICD-11 (SCII-11) is a semi-structured diagnostic interview that requires experience in clinical interviewing on the part of the interviewer. The SCII-11 is designed to be used in conjunction with the CDDR, and provides a standardized set of questions to assist researchers to elicit the information needed to conduct a differential diagnosis in the context of research studies. It will also be useful for training purposes and in clinical settings. The development of the SCII-11 required extensive decisions about operationalizing the CDDR so that they can be more reliably applied in research settings. The SCII-11 operationalized the CDDR in two different ways: by substituting more precise diagnostic thresholds and by the choice of wording of corresponding interview questions. The CDDR intentionally avoid artificially precise duration and symptom cutoffs, allowing clinicians more

flexibility for clinical judgement. The SCII-11 modifies some of the CDDR items, substituting more precise thresholds. For example, the ICD-11 CDDR for panic disorder define a panic attack as follows: “Panic attacks are discrete episodes of intense fear or apprehension also characterized by the rapid and concurrent onset of several characteristic symptoms. These symptoms may include, but are not limited to, the following…” The SCII-11 has modified this item, substituting the word “several” with “at least three”. Similarly, the CDDR incorporate many broadly defined diagnostic constructs that could be assessed in different ways. Rather than relying on the interviewer to decide the best way to assess them, the SCII-11 operationalizes diagnostic constructs through the specificity and wording of corresponding interview questions. For example, the CDDR for schizophrenia require the presence of at least two items from a list of seven, most of the time for a period of 1 month, with one of the seven being “persistent delusions (e.g. grandiose delusions, delusions of reference, persecutory delusions)”. Since there is no single question that can satisfactorily cover every type of delusion, the SCII-11 divides the assessment of delusions into separate questions corresponding to specific types of delusions (e.g. delusions of reference, persecutory delusions, Introduction

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders grandiose delusions, delusions of guilt, somatic delusions). Given that it is a semi-structured rather than a fully structured interview, the interviewing clinician also has the option of following up on particular responses or asking additional questions in order to assess the relevant phenomena fully. WHO plans to make available a list of the operational decisions implemented in the SCII-11 as a resource in the development of other instruments to encourage greater cross-instrument agreement. In addition, WHO is developing a fully structured diagnostic interview to be used in epidemiological studies and in other situations in which the SCII-11 is not feasible owing to time constraints or because it is not feasible to use trained clinicians as interviewers. The Flexible Interview for ICD-11 (FLII-11) covers common and high-burden mental disorders, but is less comprehensive than the SCII-11. It is based on the algorithms and operationalizations developed for the SCII-11 but consists entirely of closed-ended (primarily yes/no questions), and is designed for use by lay interviewers with a limited amount of training. It will also be available for electronic administration as an open-access tool for WHO member states. The Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (65,66) is a semi-structured clinical interview used by trained clinicians to assess and diagnose mental disorders among adults, originally developed as a part of a joint project of WHO and the United States National Institute of Mental Health. The SCAN comprises a set of instruments, supported by manuals, and was originally developed around the Present State Examination, which assesses a wide range of symptoms likely to be manifested during a psychotic episode. The SCAN is designed to yield both ICD and DSM diagnoses, and has been translated into more than 35 languages. It requires extensive training by an approved training centre to administer. Its approach is different from that of the SCII-11, which attempts to assess the diagnostic requirements of mental disorders more directly via direct self-report of their essential features. Version 3 of the SCAN is currently being developed and will be fully compatible with the ICD-11. It will refer to the SCII-11 operationalizations in the formulation of its diagnostic algorithms, although its assessment methodology will remain distinct. In addition, instruments focused on particular diagnoses as formulated in ICD-11 are being developed by WHO as well as by researchers external to WHO. For example, WHO is supporting the development of screening and diagnostic tools for gaming disorder (67). Instruments not sponsored by WHO include several measures of personality disorder severity and trait domains based on ICD-11

developed by different research groups (68–71). A self-report measure of ICD-11 post-traumatic stress disorder and complex post-traumatic stress disorder has been validated (72) and translated into over 25 languages. A scale designed to assess ICD-11 compulsive sexual behaviour disorder has been developed and validated (73), and will be made available in up to 30 languages as part of a large international research project (74). Ultimately, the use of the ICD-11 classification of mental, behavioural and neurodevelopmental disorders in research will depend on the development of validated measures for specific purposes, as illustrated by these examples, rather than on the development of a separate classification intended for research use.

06 - Conclusion

Conclusion

15 Conclusion As stated by the Advisory Group early in the development of ICD-11, “People are only likely to have access to the most appropriate mental health services when the conditions that define eligibility and treatment selection are supported by a precise, valid, and clinically useful classification system” (5, p. 90). The ICD-11 classification of mental, behavioural and neurodevelopmental disorders and the CDDR have taken major steps in this direction. As a part of the first major revision of the ICD in three decades, the new diagnostic classification for mental disorders and the CDDR were developed based on comprehensive reviews of available scientific evidence and best clinical practices, using a participative global, multidisciplinary and multilingual process. Clinical utility and global applicability were guiding principles of this work, which was closely linked to a systematic programme of field studies involving thousands of clinicians around the globe. The overall ICD-11 represents an enormous step forward, being based on and designed to be fully integratable with electronic health information infrastructure, which dramatically expands the capacities and flexibility of the classification system. It is likely to be the standard for global health information for some time – perhaps as long or longer than was ICD-10. A key aspect of WHO’s plans regarding ICD-11 is that regular updates will occur every 2 years; these will provide an opportunity to modify the classification to reflect new knowledge and changing circumstances. It is anticipated that a greater number of changes will be made early on, as Member States gain experience in actually using the classification. This will provide an important mechanism for making refinements or clarifications to the classification of mental, behavioural and neurodevelopmental disorders should they be justified based on emerging evidence and clinical experience. Introduction

07 - References

References

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders References2 1. World Health Assembly Update, 25 May 2019. Geneva: World Health Organization; 2019 (https://www.who.int/news/item/25-05-2019world-health-assembly-update). 2. ICD-11 Reference Guide. Geneva: World Health Organization; 2019 (https://icdcdn.who.int/ icd11referenceguide/en/html/index.html). 3. Basic documents, 49th edition. Geneva: World Health Organization; 2020 (https://apps.who. int/iris/handle/10665/339554). 4. International Statistical Classification of Diseases and Related Health Problems (ICD). Geneva: World Health Organization; 2022 (https://www.who.int/standards/classifications/ classification-of-diseases). 5. International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. A conceptual framework for the revision of the ICD-10 classification of mental and behavioural disorders. World Psychiatry. 2011;10:86–92. doi:10.1002/j.2051-5545.2011.tb00022.x. 6. Reed GM, First MB, Kogan CS, Hyman SE, Gureje O, Gaebel W et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. World Psychiatry. 2019;18:3–19. doi:10.1002/ wps.20611. 7. Rehm J, Shield KD. Global burden of disease and the impact of mental and addictive disorders. Curr Psychiatry Rep. 2019;21(2):10. doi:10.1007/s11920-019-0997-0. 8. ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) [website]. Geneva: World Health Organization; 2023 (https://ICD.who. int/browse11/l-m/en#/). 9. International statistical classification of diseases, injuries and causes of death, sixth revision. Geneva: World Health Organization; 1949. 10. Manual of the international statistical classification of diseases, injuries, and causes of death. Geneva: World Health Organization; 1957. 11. International statistical classification of diseases, injuries, and causes of death, eighth revision. Geneva: World Health Organization; 1967. 12. Glossary of mental disorders and guide to their classification. Geneva: World Health Organization; 1974. 13. International statistical classification of diseases, injuries, and causes of death, ninth revision. Geneva: World Health Organization; 1979. 2 All references accessed 22–28 February 2023. 14. International statistical classification of diseases and related health problems, 10th revision. Geneva: World Health Organization; 1992. 15. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization; 1992. 16. First MB, Reed GM, Hyman SE, Saxena S. The development of the ICD-11 clinical descriptions and diagnostic guidelines for mental and behavioural disorders. World Psychiatry. 2015;14(1):82–90. doi:10.1002/wps.20189. 17. Keeley JW, Reed GM, Roberts MC, Evans SC, Medina-Mora ME, Robles R et al. Developing a science of clinical utility in diagnostic classification systems field study strategies for ICD-11 mental and behavioral disorders. Am Psychol. 2016;71(1):3–16. doi:10.1037/ a0039972. 18. Reed GM, Sharan P, Rebello TJ, Keeley JW, Medina-Mora ME, Gureje O et al. The ICD11 developmental field study of reliability of diagnoses of high-burden mental disorders: results among adult patients in mental health settings of 13 countries. World Psychiatry. 2018;17(2):174–86. doi:10.1002/wps.20524. 19. Reed GM,

Keeley JW, Rebello TJ, First MB, Gureje O, Ayuso-Mateos JL et al. Clinical utility of ICD-11 diagnostic guidelines for high-burden mental disorders: results from mental health settings in 13 countries. World Psychiatry. 2018;17(3):306–15. doi:10.1002/ wps.20581. 20. Gaebel W. Status of psychotic disorders in ICD-11. Schizophr Bull. 2012;38(5):895–8. doi:10.1093/schbul/sbs104. 21. Maj M, Reed GM, editors. The ICD-11 classification of mood and anxiety disorders: Background and options. World Psychiatry. 2012;11(Suppl. 1). 22. Stein DJ, Kogan CS, Atmaca M, Fineberg NA, Fontenelle LF, Grant JE et al. The classification of obsessive-compulsive and related disorders in the ICD-11. J Affect Disord. 2016;190:663–74. doi:10.1016/j.jad.2015.10.061. 23. Kogan CS, Stein DJ, Maj M, First MB, Emmelkamp PM, Reed GM. The classification of anxiety and fear-related disorders in the ICD-11. Depress Anxiety. 2016;33(12):1141–54. doi:10.1002/da.22530. 24. Maercker A, Brewin CR, Bryant RA, Cloitre M, van Ommeren M, Jones LM et al. Diagnosis and classification of disorders specifically associated with stress: proposals for ICD-11. World Psychiatry. 2013;12(3):198–206. doi:10.1002/ wps.20057.

25. Poznyak V, Reed GM, Medina-Mora ME. Aligning the ICD-11 classification of disorders due to substance use with global service needs. Epidemiol Psychiatr Sci 2018;27(3):212–18. doi:10.1017/S2045796017000622.
26. Krueger RB, Reed GM, First MB, Marais A, Kismodi E, Briken P. Proposals for paraphilic disorders in the International Classification of Diseases and Related Health Problems, Eleventh Revision (ICD-11). Arch Sex Behav. 2017;46(5):1529–45. doi:10.1007/s10508-0170944-2.
27. Fuss J, Lemay K, Stein DJ, Briken P, Jakob R, Reed GM et al. Public stakeholders' comments on ICD-11 chapters related to mental and sexual health. World Psychiatry. 2019;18(2):233–5. doi:10.1002/wps.20635.
28. Guler J, Roberts MC, Medina-Mora ME, Robles R, Gureje O, Keeley JW et al. Global collaborative team performance for the revision of the International Classification of Diseases: a case study of the World Health Organization Field Studies Coordination Group. Int J Clin Health Psychol. 2018;18(3):189–200. doi:10.1016/j. ijchp.2018.07.001.
29. Reed GM, Mendonça Correia J, Esparza P, Saxena S, Maj M. The WPA-WHO Global Survey of Psychiatrists' Attitudes Towards Mental Disorders Classification. World Psychiatry. 2011;10(2):118–
30. doi:10.1002/j.2051-5545.2011.tb00034.x.
31. Evans SC, Reed GM, Roberts MC, Esparza P, Watts AD, Correia JM et al. Psychologists' perspectives on the diagnostic classification of mental disorders: results from the WHO-IUPsyS Global Survey. Int J Psychol. 2013;48(3):177–93. doi:10.1080/00207594.2013.804189.
32. Robles R, Fresán A, Evans SC, Medina-Mora ME, Maj M, Reed GM. Problematic, absent and stigmatizing diagnoses in current mental disorders classifications: results from the WHOWPA and WHO-IUPsyS Global Surveys. Int J Clin Health Psychol. 2014;14(3):165–77. doi:10.1016/j.ijchp.2014.03.003.
33. Robles R, Fresán A, Medina-Mora ME, Sharan P, Roberts MC, Mari JJ et al. Categories that should be removed from mental disorders classifications: perspectives and rationales of clinicians from eight countries. J Clin Psychol. 2015;71(3):267–
34. doi:10.1002/jclp.22145.
35. Roberts MC, Reed GM, Medina-Mora ME, Keeley JW, Sharan P, Johnson DK et al. A global clinicians' map of mental disorders to improve ICD-11: analysing meta-structure to

enhance clinical utility. Int Rev Psychiatry. 2012;24(6):578–90. doi:10.3109/09540261.2012.736368.
36. Reed GM, Roberts MC, Keeley J, Hooppell C, Matsumoto C, Sharan P et al. Mental health professionals' natural taxonomies of mental disorders: implications for the clinical utility of the ICD-11 and the DSM-5. J Clin Psychol. 2013;69(12):1191–212. doi:10.1002/jclp.22031. Introduction
37. Evans SC, Roberts MC, Keeley JW, Blossom JB, Amaro CM, Garcia AM et al. Vignette methodologies for studying clinicians' decisionmaking: validity, utility, and application in ICD-11 field studies. Int J Clin Health Psychol. 2015;15(2):160–70. doi:10.1016/j.ijchp.2014.12.001.
38. Keeley JW, Gaebel W, First MB, Peterson DL, Rebello T, Sharan P et al. Psychotic disorder symptom rating scales: are dichotomous or multi-point scales more clinically useful? – An ICD-11 field study. Schizophr Res. 2018;202:254–
39. doi:10.1016/j.schres.2018.07.006.
40. First MB, Rebello TJ, Keeley JW, Bhargava R, Dai Y, Kulygina M et al. Do mental health professionals use diagnostic classifications the way we think they do? A global survey. World Psychiatry. 2018;17(2):187–95. doi:10.1002/ wps.20525.
41. Keeley JW, Briken P, Evans SC, First MB, Klein V, Krueger RB et al. Can clinicians use dimensional information to make a categorical diagnosis of paraphilic disorders? An ICD-11 field study. J Sex Med. 2021;18(9):1592–606. doi:10.1016/j.jsxm.2021.06.016.
42. Keeley JW, Reed GM, Roberts MC, Evans SC, Robles R, Matsumoto C et al. Disorders specifically associated with stress: a case-controlled field study for ICD-11 mental and behavioural disorders. Int J Clin Health Psychol. 2016;16(2):109–27. doi:10.1016/j.ijchp.2015.09.002.
43. Claudino AM, Pike KM, Hay P, Keeley JW, Evans SC, Rebello TJ et al. The classification of feeding and eating disorders in the ICD-11: results of a field study comparing proposed ICD-11 guidelines with existing ICD-10 guidelines. BMC Med. 2019;17(1):93. doi:10.1186/s12916-019-1327-4.
44. Peterson DL, Webb CA, Keeley JW, Gaebel W, Zielasek J, Rebello TJ et al. The reliability and clinical utility of ICD-11 schizoaffective disorder: a field trial. Schizophr Res. 2019;208:235–41. doi:10.1016/j.schres.2019.02.011.
45. Rebello TJ, Keeley JW, Kogan CS, Sharan P, Matsumoto C, Kuligyna M et al. Anxiety and fear-related disorders in the ICD-11: results from a global case-controlled field study. Arch Med Res. 2019;50(8):490–501. doi:10.1016/j.arcmed.2019.12.012.
46. Kogan CS, Stein DJ, Rebello TJ, Keeley JW, Chan KJ, Fineberg NA et al. Accuracy of diagnostic judgements using ICD-11 vs. ICD-10 diagnostic guidelines for obsessive-compulsive and related disorders. J Affect Disord. 2020;273:328–40. doi:10.1016/j.jad.2020.03.103.
47. Kogan CS, Maj M, Rebello TJ, Keeley JW, Kulygina M, Matsumoto C et al. A global field study of the International Classification of Diseases (ICD-11) mood disorders clinical descriptions and diagnostic guidelines. J Affect Disord. 2021;295:1138–50. doi:10.1016/j.jad.2021.08.050.

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders 45. Evans SC, Roberts MC, Keeley JW, Rebello TJ, de la Peña F, Lochman JE et al. Diagnostic classification of irritability and oppositionality in youth: a global field

study comparing ICD11 with ICD-10 and DSM-5. J Child Psychol Psychiatry. 2021;62(3):303–12. doi:10.1111/ jcpp.13244. 46. Gaebel W, Stricker J, Riesbeck M, Zielasek J, Kerst A, Meisenzahl-Lechner E et al. Accuracy of diagnostic classification and clinical utility assessment of ICD-11 compared to ICD-10 in 10 mental disorders: findings from a web-based field study. Eur Arch Psychiatry Clin Neurosci. 2020;270(3):281–9. doi:10.1007/s00406-01901076-z. 47. Gaebel W, Riesbeck M, Zielasek J, Kerst A, Meisenzahl-Lechner E, Köllner V et al. Internetbasierte Untersuchungen zur diagnostischen Klassifikation und Kodierung psychischer Störungen im Vergleich von ICD-11 und ICD-10 [Web-based field studies on diagnostic classification and code assignment of mental disorders: comparison of ICD11 and ICD-10]. Fortschr Neurol Psychiatr. 2018;86(3):163–71. doi:10.1055/s-0044-100508 (in German). 48. Robles R, de la Peña FR, Medina-Mora ME, Marquéz-Caraveo MED, Domínguez T, Juárez F et al. ICD-11 guidelines for mental and behavioral disorders of children and adolescents: Reliability and clinical utility. Psychiatr Serv. 2022;73(4):396-402. doi: 10.1176/appi. ps.202000830. 49. Lemay KR, Kogan CS, Rebello TJ, Keeley JW, Bhargava R, Sharan P et al. An international field study of the ICD-11 behavioural indicators for disorders of intellectual development. J Intellect Disabil Res. 2022;66(4):376–91. doi:10.1111/ jir.12924. 50. Degenhardt L, Bharat C, Bruno R, Glantz MD, Sampson NA, Lago L et al. Concordance between the diagnostic guidelines for alcohol and cannabis use disorders in the draft ICD-11 and other classification systems: analysis of data from the WHO's World Mental Health Surveys. Addiction. 2019;114(3):534–52. doi:10.1111/ add.14482. 51. Diagnostic and Statistical Manual of Mental Disorders, 4th edition. Washington DC: American Psychiatric Association; 1994. 52. Diagnostic and statistical manual of mental disorders, 5th edition. Arlington, VA: American Psychiatric Association; 2013. 53. Hackmann C, Balhara YPS, Clayman K, Nemec PB, Notley C, Pike K et al. Perspectives on ICD-11 to understand and improve mental health diagnosis using expertise by experience (INCLUDE Study): an international qualitative study. Lancet Psychiatry. 2019;6(9):778–85. doi:10.1016/S2215-0366(19)30093-8. 54. Roelandt JL, Baleige A, Koenig M, Demassiet V, Agoub M, Barikova V et al. How service users and carers understand, perceive, rephrase, and communicate about "depressive episode" and "schizophrenia" diagnoses: an international participatory research. Soc Psychiatry Psychiatr Epidemiol. 2020;55(9):1201–13. doi:10.1007/ s00127-020-01836-6. 55. First MB, Gaebel W, Maj M, Stein DJ, Kogan CS, Saunders JB et al. An organization- and categorylevel comparison of diagnostic requirements for mental disorders in ICD-11 and DSM-5. World Psychiatry. 2021;20(1):34–51. doi:10.1002/ wps.20825. 56. Reed GM, First MB, Billieux J, Cloitre M, Briken P, Achab S et al. Emerging experience with selected new categories in the ICD-11: complex PTSD, prolonged grief disorder, gaming disorder, and compulsive sexual behaviour disorder. World Psychiatry. 2022;21(2):189–213. doi:10.1002/ wps.20960. 57. Reed GM, Drescher J, Krueger RB, Atalla E, Cochran SD, First MB et al. Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. World Psychiatry. 2016;15(3):205–21. doi:10.1002/ wps.20354. 58. Robles R, Fresán A, Vega-Ramírez H, Cruz-Islas J, Rodríguez-Pérez V, Domínguez-Martínez T et al. Removing transgender identity from the classification of mental disorders: a Mexican field study for ICD-11. Lancet Psychiatry. 2016;3(9):850–9. doi:10.1016/S22150366(16)30165-1. 59. Robles R, Keeley JW, Vega-Ramírez H, Cruz-Islas J, Rodríguez-Pérez V, Sharan P et al. (2021). Validity of categories related to gender identity in ICD-11 and DSM-5 among transgender individuals who seek genderaffirming medical procedures. Int J Clin Health Psychol. 2022;22(1):100281. doi:10.1016/ j.ijchp.2021.100281. 60. Gureje O, Lewis-Fernandez R, Hall BJ, Reed GM. Systematic inclusion of culture-related information in ICD-11. World Psychiatry. 2019;18(3):357–8. doi:10.1002/wps.20676. 61. Gureje O, Lewis-

Fernandez R, Hall BJ, Reed GM. Cultural considerations in the classification of mental disorders: why and how in ICD-11. BMC Med. 2020;18(1):25. doi:10.1186/s12916-0201493-4. 62. Reed GM, Rebello TJ, Pike KM, MedinaMora ME, Gureje O, Zhao M et al. WHO's Global Clinical Practice Network for mental health. Lancet Psychiatry. 2015;2(5):379–80. doi:10.1016/S2215-0366(15)00183-2.

63. The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research. Geneva: World Health Organization; 1993 (https://apps.who.int/iris/handle/10665/37108).
64. First MB. Harmonisation of ICD-11 and DSM-V: opportunities and challenges. Br J Psychiatry. 2009;195(5):382–90. doi:10.1192/bjp. bp.108.060822.
65. Wing JK, Babor T, Brugha T, Burke J, Cooper JE, Giel R et al. SCAN. Schedules for Clinical Assessment in Neuropsychiatry. Arch Gen Psychiatry. 1990;47(6):589–93. doi:10.1001/archpsyc.1990.01810180089012.
66. Rijnders CA, van den Berg JF, Hodiamont PP, Nienhuis FJ, Furer JW, Mulder J et al. Psychometric properties of the Schedules for Clinical Assessment in Neuropsychiatry (SCAN-2.1). Soc Psychiatry Psychiatr Epidemiol. 2000;35(8):348–52. doi:10.1007/s001270050249.
67. Carragher N, Billieux J, Bowden-Jones H, Achab S, Potenza MN, Rumpf HJ et al. Brief overview of the WHO Collaborative Project on the Development of New International Screening and Diagnostic Instruments for Gaming Disorder and Gambling Disorder. Addiction. 2021;117(7):2119–21. doi:10.1111/add.15780.
68. Clark LA, Corona-Espinosa A, Khoo S, Kotelnikova Y, Levin-Aspenson HF, SerapioGarcía G et al. Preliminary scales for ICD-11 personality disorder: self and interpersonal dysfunction plus five personality disorder trait domains. Front Psychol. 2021;12:668724. doi:10.3389/fpsyg.2021.668724. Introduction
69. Oltmanns JR, Widiger TA. A self-report measure for the ICD-11 dimensional trait model proposal: the personality inventory for ICD-11. Psychol Assess. 2018;30(2):154–69. doi:10.1037/ pas0000459.
70. Bach B, Brown TA, Mulder RT, Newton-Howes G, Simonsen E, Sellbom M. Development and initial evaluation of the ICD-11 personality disorder severity scale: PDS-ICD-11. Personal Ment Health. 2021;15(3):223–36. doi:10.1002/ pmh.1510.
71. Olajide K, Munjiza J, Moran P, O'Connell L, Newton-Howes G, Bassett P et al. Development and psychometric properties of the Standardized Assessment of Severity of Personality Disorder (SASPD). J Pers Disord. 2018;32(1):44–56. doi:10.1521/pedi_2017_31_285.
72. Cloitre M, Shevlin M, Brewin CR, Bisson JI, Roberts NP, Maercker A et al. The International Trauma Questionnaire: development of a self- report measure of ICD-11 PTSD and complex PTSD. Acta Psychiatr Scand. 2018;138(6):536–
73. doi:10.1111/acps.12956.
74. Bőthe B, Potenza MN, Griffiths MD, Kraus SW, Klein V, Fuss J et al. The development of the Compulsive Sexual Behavior Disorder Scale (CSBD-19): an ICD-11 based screening measure across three languages. J Behav Addict. 2020;9(2):247–58. doi:10.1556/2006.2020.00034.
75. Bőthe B, Koós M, Nagy L, Kraus SW, Potenza MN, Demetrovics Z. International Sex Survey: study protocol of a large, cross-cultural collaborative study in 45 countries. J Behav Addict. 2021;10(3):632–45. doi:10.1556/2006.2021.00063.

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders