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Letter to the Editor

THE ICD-11 CHAPTER ON MENTAL DISORDERS: AN UPDATE FOR WPA COMPONENTS

Dear Editor,

A draft of the Clinical Descriptions and Diagnostic Guidelines for the 11th edition of the International Classification of Diseases and Related Health Problems (ICD-11) has been recently produced by the World Health Organization (WHO) (Reed et al. 2016a). This draft covers at the moment five groupings of disorders: schizophrenia and other primary psychotic disorders, mood disorders, anxiety and fear-related disorders, disorders specifically associated with stress, and feeding and eating disorders. For all other groupings of disorders, a brief general definition and sometimes a description of some of the disorders included in the grouping can be found on the ICD-11 beta platform (Luciano 2015).

All these materials are not to be regarded as definitive. Indeed, the WHO welcomes comments and suggestions from the field (First et al. 2015, Reed et al. 2016a). In order to collect these comments and suggestions, an Internet platform called GCP.Network has been created, which can be accessed by all the members of the Global Clinical Practice Network. This Network can be joined by all mental health or primary care professionals who are legally authorized to provide services to people with mental and behavioural disorders in their countries. At present, the Network consists of more than 12,600 mental health and primary care professionals from almost 150 countries, over half of whom are psychiatrists (see http://gcp.network to register in any of nine languages).

The final version of the ICD-11 chapter on mental and behavioural disorders, which is expected to be approved by the World Health Assembly in May 2018, will include the following groupings: neurodevelopmental disorders; schizophrenia and other primary psychotic disorders; mood disorders; anxiety and fear-related disorders; obsessive-compulsive and related disorders; disorders specifically associated with stress; dissociative disorders; bodily distress disorders; feeding and eating disorders; elimination disorders; disorders due to substance use; impulse control disorders; disruptive behaviour and dissocial disorders; personality disorders; paraphilic disorders; factitious disorders; neurocognitive disorders; and mental and behavioural disorders due to disorders or diseases classified elsewhere.

Sleep-wake disorders and conditions related to sexual health will be covered in separate chapters of the classification (i.e., not in the chapter on mental and behavioural disorders). This decision has been taken in order to overcome the ICD-10 distinction, regarded as obsolete, between "organic" and "non-organic" sleep disorders (included, respectively, in the chapters on diseases of the nervous system and on mental and behavioural disorders) and between "organic" and "non-organic" sexual dysfunctions (included, respectively, in the chapters on diseases of the genitourinary system and on mental and behavioural disorders).

The proposed ICD-11 diagnostic guidelines subdivide sexual dysfunctions into four main groups: sexual desire and arousal dysfunctions; orgasmic dysfunctions; ejaculatory dysfunctions; and other specified sexual dysfunctions. The conditions which appeared as gender identity disorders in ICD-10 have been reconceptualized as "gender incongruence", and also proposed to be moved to the new chapter on sexual health. The ICD-10 categories related to sexual orientation have been recommended for deletion from the ICD-11 (Cochran et al. 2014, Chou et al. 2015, Drescher 2015, Reed et al. 2016b).

For each disorder included in the above-mentioned groupings, the ICD-11 clinical descriptions and diagnostic guidelines will provide: a) a brief definition; b) a list of inclusion and exclusion terms; c) a description of the essential (required) features; d) a guidance concerning the differentiation between the disorder and some relevant "normal" conditions ("boundary with normality"); e) a list of the disorders that should be distinguished from the one being described and a guidance on how to make the differential diagnosis ("boundary with other disorders (differential diagnosis)"); f) coded qualifiers and subtypes; g) clinically relevant information regarding the typical course ("course features"); h) "associated clinical presentations"; i) culture-related features; j) developmental presentations (i.e., a description of how the disorder may present differently according to the developmental stage of the individual, including childhood, adolescence and older adulthood); l) gender-related features (First et al. 2015).

In the subsequent sections of the present paper, we provide some information on the content of the current draft of the ICD-11 clinical descriptions and diagnostic guidelines, based on the available materials, with the understanding that some aspects may be still subject to revision, also on the basis of the results of the ongoing field studies (Sampogna 2015).

In the ICD-11 grouping of "Schizophrenia and other primary psychotic disorders", the diagnosis of schizophrenia requires the presence of two from a list of seven symptoms, at least one of which must be delusions, hallucinations, disorganized thinking, or experiences of influence, passivity or control. The subtypes of schizophrenia described in the ICD-10 do not appear anymore, because of the evidence that they frequently change over time and are not useful for prognostic or therapeutic purposes. Course qualifiers have been introduced in order to specify the episodicity (first episode, multiple episodes, continuous course) and the current symptomatic status (currently symptomatic, in partial remission, in full remission). Symptom qualifiers are also provided, in order to allow the clinician to describe the severity of symptoms in each of six domains: positive symptoms, negative symptoms, depressive mood, manic mood, psychomotor symptoms, and cognitive symptoms. The definition of schizoaffective disorder has remained largely unchanged, still requiring that the individual meets the diagnostic guidelines for schizophrenia and a mood episode (depressive, manic or mixed) simultaneously, without the specifications concerning the relative duration of the psychotic and mood components provided in the DSM-5 (Gaebel 2012). In the section "Boundary with other disorders and normality", the differential diagnosis is delineated between schizophrenia and psychotic-like symptoms occurring in the general population (van Os and Reininghaus 2016, Lawrie 2016, Parnas 2016, Tandon 2016). No mention is made in the ICD-11 draft of the "attenuated psychosis syndrome" which appears in the section III of the DSM-5 (Fusar-Poli et al. 2015 and 2016, Schimmelmann et al. 2015 and Yung and Lin 2016).

In the ICD-11 grouping of mood disorders, bipolar II disorder is recognized as a distinct diagnostic entity (while it was just mentioned among "other bipolar affective disorders" in the ICD-10). Increased activity or a subjective experience of increased energy becomes a prerequisite for the diagnosis of manic episode, similarly to the DSM-5. It is acknowledged that a manic or hypomanic syndrome emerging during antidepressant treatment, and persisting beyond the physiological effect of that treatment, qualifies for the diagnosis of manic/hypomanic episode. Contrary to the DSM-5, the category of mixed episode is kept, defined by the presence of persistent and prominent manic and depressive symptoms in a single episode lasting for at least two weeks. Symptoms may either occur simultaneously or alternate very rapidly from day to day or within the same day. It is specified that, when the depressive symptoms predominate in a mixed episode, common contrapolar symptoms are irritability, racing or crowded thoughts, increased talkativeness and psychomotor agitation (Maj 2013). This divergence from the DSM-5 is supported by the recent empirical evidence that the DSM-5 definition of "major depression with mixed features" fails to capture the essence of mixed depression as described in the literature (Perlis et al. 2014, Miller et al. 2016). In the ICD-11 draft, it is specified that common expressions of grief, consistent with the normative response to the loss of a loved one within the individual's religious and cultural context, can include depressive symptoms and do not warrant a depressive episode diagnosis. It is, however, acknowledged that a depressive episode can be superimposed on normal grief (Bolton et al. 2016), and guidance is provided about the elements which suggest the presence of a depressive episode during a period of bereavement. The ICD-11 will not follow the DSM-5 in the introduction of the new category of disruptive mood dysregulation disorder; a specifier "with chronic irritability or anger" will be instead added to the category of oppositional defiant disorder (Lochman et al. 2015).

In the ICD-11 draft, obsessive-compulsive and related disorders and disorders specifically associated with stress have been separated from anxiety and fear-related disorders, while two childhood disorders have been moved to this latter grouping,

i.e. separation anxiety disorder and selective mutism (Kogan et al. 2016, Stein et al. 2016). In the ICD-11 draft, separation anxiety disorder can be diagnosed in adults as well as in children (Silove et al. 2016). Generalized anxiety disorder is no longer a diagnosis of exclusion but has a more elaborated set of essential features, including marked symptoms of anxiety accompanied by either general apprehensiveness or worry about negative events occurring in several different aspects of everyday life. The ICD-11 draft also includes additional symptoms accompanying general apprehensiveness or worry, such as muscle tension and autonomic overactivity. In the ICD-11 draft, agoraphobia is no longer considered primary to panic disorder; they can be diagnosed independently or together. Social anxiety disorder replaces the ICD-10 diagnosis of social phobia, and guidance is provided to differentiate this disorder from normal age-appropriate fears.

The new grouping of disorders specifically associated with stress includes disorders that are directly related to exposure to a stressful or traumatic event, or a series of such events or adverse experiences. The grouping comprises post-traumatic stress disorder, complex post-traumatic stress disorder, prolonged grief disorder, adjustment disorder, and other disorders specifically associated with stress. Acute stress reaction is not considered to be a mental disorder, but rather appears in the ICD-11 section including reasons for clinical encounters that are not diseases or disorders. The category of complex post-traumatic stress disorder, not present in either ICD-10 or DSM-5, is characterized by the three core elements of post-traumatic stress disorder (i.e., re-experiencing the traumatic event(s) in the present, deliberate avoidance of reminders likely to produce this re-experience, and persistent perceptions of heightened current threat) plus severe and pervasive problems in affect regulation; persistent beliefs about oneself as diminished, defeated or worthless; and persistent difficulties in sustaining relationships and in feeling close to others. The category of prolonged grief disorder, not present in the ICD-10 and corresponding to the "persistent complex bereavement disorder" included in the section III of DSM-5, is characterized by a pervasive grief response, persisting for an abnormally long period of time following the loss, clearly exceeding expected social or religious norms for the individual's culture and context, and causing significant social impairment (Cloitre et al. 2013, Maercker et al. 2013, Bryant 2014, Maciejewski et al. 2016, Keeley et al. 2016).

The grouping of feeding and eating disorders, involving abnormal eating or feeding behaviours that are not better accounted for by another health condition and are not developmentally appropriate or culturally sanctioned, includes the new category of avoidant-restrictive food intake disorder, whose essential features are avoidance or restriction of food intake, characterized by eating an insufficient quantity or variety of food in order to meet adequate energy or nutritional requirements for the individual, leading to significant weight loss (or failure to gain weight) or other impact on physical health, and not reflecting preoccupation with body weight or shape or a significant body image distortion. In the category of anorexia nervosa, since severe underweight status is an important prognostic factor associated with high risk of physical complications and substantially increased mortality, qualifiers "with significantly low body weight" and "with dangerously low body weight", anchored to body mass index values, are provided. The proposed definition of binge eating for the diagnoses of bulimia nervosa and binge eating disorder involves an episode during which the individual experiences loss of control over eating, eats notably more or differently than usual, and feels unable to stop eating or limit the type or amount of food eaten. Thus, it is not necessary to consume an objectively large amount of food during a binge eating episode; a subjectively large amount or abnormal type of food in the context of loss of control would be sufficient to meet the diagnosis (Al-Adawi et al. 2013).

Bodily distress disorder is defined in the ICD-11 draft by the presence of bodily symptoms that are distressing to the individual and by the excessive attention directed toward the symptoms, which may be manifest by repeated contact with health care providers. If a medical condition is causing or contributing to the symptoms, the degree of attention is clearly excessive in relation to its nature and progression. Excessive attention is not alleviated by appropriate clinical examination and investigations and adequate reassurance. Bodily symptoms and associated distress are persistent, and are associated with significant functional impairment. Thus, the distinction between medically explained and medically unexplained somatic complaints is eliminated, and the problem – criticized in the ICD-10 – of defining somatoform disorders on the basis of the absence of a feature (a physical or medical cause) is addressed by specifying the features that must be present, such as distress and excessive thoughts and behaviours (Gureje and Reed 2016).

Impulse control disorders are characterized on the ICD-11 beta platform by the repeated failure to resist an impulse, drive or urge to perform an act that is rewarding to the person, at least in the short term, despite longer-term harm. The behaviour pattern causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Pathological gambling is going to be included in this grouping in the ICD-11, rather than appearing among addictive disorders as in the DSM-5 (Grant et al. 2014, Mann et al. 2016).

On the ICD-11 beta platform, personality disorder is defined by a relatively enduring and pervasive disturbance in how individuals experience and interpret themselves, others and the world, that results in maladaptive patterns of cognition, emotional experience, emotional expression and behaviour.

These maladaptive patterns are relatively inflexible and are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships. The most significant change with respect to the ICD-10 and DSM-5 is the abolition of the individual personality disorder categories, while the primary classification is made on the basis of a single dimension of severity. The system of categories is replaced by a system of monothetic domain traits (detached, dissocial, disinhibited, distressed, ananchastic), which is still under review (Tyrer et al. 2011, Kim et al. 2014, Tyrer et al. 2015, Kim et al. 2015).

Internet-based and clinic-based field studies aiming to test the ICD-11 draft of the clinical descriptions and diagnostic guidelines for the various disorders are now ongoing (Evans et al. 2015, Keeley et al. 2016). Internet-based field studies use a case vignette methodology to examine clinical decision-making in relation to the proposed ICD-11 guidelines, and are being conducted through the Global Clinical Practice Network. Clinic-based field trials aim to assess the reliability and utility of the proposed ICD-11 guidelines in the clinical settings where the classification will be used, and are being conducted through the WHO Network of International Field Study Centres.

While clinical utility has been emphasized as a primary objective of the previous versions of the ICD as well as of the DSM-III and its successors (First et al. 2015), and has been often regarded as the highest priority in diagnostic systems (Frances 2016, Jablensky 2016) – although different views have been also expressed (Bolton 2016, Ghaemi 2016, Wakefield 2016) – this is in fact the first time that the clinical utility of a psychiatric diagnostic system is being tested systematically.

Throughout the ICD-11 draft, the description of the essential (required) features of the various mental disorders usually lack the specific thresholds concerning number and duration of symptoms that characterize the DSM-III and its successors. Instead, the diagnostic guidelines are intended to conform to the way psychiatrists actually make diagnoses in ordinary practice, i.e., by the flexible exercise of clinical judgment (First et al. 2015, Parnas 2015).

The possibility of a dialogue between the ICD revision process and the Research Domain Criteria (RDoC) project launched by the US National Institute of Mental Health is being considered. Indeed, the main objectives of the two projects (i.e., improving the clinical utility of psychiatric diagnoses for the ICD; exploring in an innovative way the etiopathogenetic bases of psychopathology for the RDoC) can be regarded as complementary, and much can be done to reduce the current gap between the RDoC constructs and the clinical phenomena that psychiatrists encounter in their ordinary practice, especially in the area of psychoses (Frangou et al. 2016, Maj 2016, Sanislow 2016).

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MD., Mario Luciano *WHO Collaborating Center for Research and Training in Mental Health, University of Naples SUN, Naples, Italy*
e-mail: mario.luciano@unina2.it

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