Psychiatr. Pol. 2017; 51(2): 169–195
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/69660

Mental and behavioural disorders in the ICD-11: concepts, methodologies, and current status

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Summary

This review provides an overview of the concepts, methods and current status of the development of the Eleventh Revision of the Mental and Behavioural Disorders chapter of the International Classification of Diseases and Related Health Problems (ICD-11) by the World Health Organization (WHO). Given the global use of the current version (ICD-10) for a wide range of applications in clinical practice and health statistics, a major aim of the development process for ICD-11 has been to increase the utility of the classification system. Expert working groups with responsibility for specific disorder groupings first suggested a set of revised diagnostic guidelines. Then surveys were performed to obtain suggestions for revisions from practicing health professionals. A completely revised structure for the classification of mental and behavioural disorders was developed and major revisions were suggested, for example, for schizophrenia and other primary psychotic disorders, substance use disorders, affective disorders and personality disorders. A new category of "gaming disorder" has been proposed and conditions related to sexual health and gender identity will be classified separately from mental disorders. An ICD-11 beta draft is freely available on the internet and public comments are invited. Field studies of the revised diagnostic guidelines are in process to obtain

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additional information about necessary improvements. A tabulated crosswalk from previous ICD-10 to then ICD-11 criteria will be necessary to ascertain the continuity of diagnoses for epidemiological and other statistical purposes. The final version of ICD-11 is currently scheduled for release by the World Health Assembly in 2018.

Key words: ICD-11, classification, mental and behavioural disorders

Introduction

The major global classification system for statistical and clinical documentation of disorders is the International Classification of Diseases and Related Health Problems (ICD), published by the World Health Organization. The Tenth Revision of the ICD (ICD-10) was published in 1990. Although WHO updates the ICD-10 on a regular basis to integrate new disorders and evolving concepts in their definition, a major revision of the classification of disorders was long overdue and was officially initiated by WHO in 2005. Technical responsibility for managing the activities related to the revision of the chapter on Mental and Behavioural Disorders was assigned to the WHO Department of Mental Health and Substance Abuse, which appointed the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders in 2007 [1]. WHO, with the advice of the Advisory Group, appointed expert Working Groups to recommend changes to specific areas in the "Mental and behavioural disorders" chapter based on reviews of the available evidence and current practice. Working Groups were asked to develop source materials for ICD-11 diagnostic guidelines based on principles established by the International Advisory Group [1] according to a standard format [2], and to consider the proposals and, later, published criteria for DSM-5 [3] in developing their recommendations. At the time of writing this review in mid-2016, a first "beta draft" of the revised categories and definitions for ICD-11 is publicly available on the internet (http://apps.who.int/classifications/icd11/browse/f/en). More detailed draft diagnostic guidelines for Mental and Behavioural Disorders are also currently available for review and comment by members of WHO's Global Clinical Practice Network [4] (http://gcp.network) and are currently being tested in a range of field studies [5]. These materials provided the basis for the current review.

Methods of this review

A review of the methods and results of the process of developing the "Mental and behavioural disorders" chapter of ICD-11 was performed using information available in publications about the process and other information available to the first author as a member of the WHO International Advisory Group, as the Chair of the WHO ICD-11 Working Group on Schizophrenia and Other Primary Psychotic Disorders, and as a member of the WHO Field Studies Coordination Group for ICD-11 "Mental

and behavioural disorders" and to the last author as the primary member of the WHO Secretariat coordinating these activities.

Results

Concepts of the revision process

The ICD-11 is intended as a freely available and open global resource, usable as a tool for clinical practitioners, researchers, patients, administrators, policy makers and governments. This implies that several versions may be prepared and published, for example for use in morbidity and mortality statistics, in clinical settings by mental health specialists, in primary health care settings, and for research purposes. A central concept has been to develop ICD-11 in collaboration with stakeholders including representatives of WHO Member States, multidisciplinary health professionals, and users of mental health services and their families. A major goal was to improve the clinical utility of the classification system and its usefulness to reduce global disease burden associated with mental and behavioural disorders, especially in low – and middle-income countries, by providing a better tool for the identification of people who need mental health services and the treatments most likely to be effective [1]. Thus, the process has been based on scientific evidence provided by: recommendations and materials developed by the disorder-specific working groups (Table 1); stakeholder input through comments on the draft versions published on the internet; and through specific surveys and field studies. The imperative of global applicability has informed the composition of Working Groups and methodologies for field testing.

Table 1. **ICD-11 Working and Consultation Groups* (Mental and Behavioural Disorders), the group leaders and their country (G. M. Reed, personal communication)**

ICD-11 Working and Consultation Groups	Group leaders	Group leaders' country of origin
International Advisory Group	Steve Hyman	U.S.A
Field Studies Coordination Group	María Elena Medina Mora	Mexico
Children and adolescents	Elena Garralda	U.K.
Culture and diagnosis	Oye Gureje Roberto Lewis-Fernández	Nigeria U.S.A.
Feeding and eating disorders	Angelica Claudino	Brazil
Intellectual developmental disorders	Luís Salvador-Carulla	Spain
Mood and anxiety disorders	Mario Maj	Italy
Neurocognitive disorders	Paulo Caramelli	Brazil
Obsessive-compulsive and related disorders	Dan Stein	South Africa
Older adults	Armin von Gunten	Switzerland
Personality disorders	Peter Tyrer	U.K.

table continued on the next page

Primary care	David Goldberg	U.K.
Psychotic disorders	Wolfgang Gaebel	Germany
Sexual disorders and sexual health	Jane Cottingham	U.S.A.
Somatic distress and dissociative disorders	Oye Gureje	Nigeria
Disorders specifically associated with stress	Andreas Maercker	Switzerland
Disorders due to substance use and addictive behaviours	Vladimir Poznyak	WHO, Geneva, Switzerland

***** Some of these groups have completed their tasks and are not meeting

Methods of the revision process

The surveys were initiated as formative field studies to perform international surveys of professionals regarding their perspectives on classification, patterns of use and perceived necessary changes. They were also used to investigate professionals' concepts of mental disorders and their classification.

Based on the deliberations of the Working Groups and the results of the formative field studies, WHO has developed a set of Clinical Descriptions and Diagnostic Guidelines (CDDG) [2]. These are being used as the basis for the ensuing internet-based and clinical field trials (*evaluative field studies*). The internet-based field studies are international, multilingual studies that use standardised case material in the form of vignettes in which specific diagnostic features are controlled to elucidate the diagnostic decision-making process using the proposed ICD-11 diagnostic guidelines, and to compare the accuracy and consistency resulting from their use with the existing diagnostic guidelines for ICD-11. These studies are in the process of being completed and published, and one is already available [6]. A second set of "ecological implementation" field studies applying ICD-11 beta draft criteria to "real" patients in clinical setting are also being conducted in International Field Study Centers around the world. These include studies of diagnostic consistency (reliability) using two raters for psychotic, mood, anxiety, and stress-related disorders, as well as for common childhood disorders. Additional ecological implementation studies focus on the clinical utility (e.g., ease of use, goodness of fit) for other groupings of disorders. These clinical field studies are being conducted under the guidance of a Field Studies Coordinating Group established by WHO to assist in their implementation in 18 countries representing all regions of the world (Table 2).

Table 2. **Countries in which clinic-based field trials are currently being implemented or planned**

Number	Country
1.	Brazil

table continued on the next page

2.	Canada
3.	China
4.	Egypt
5–7	German-speaking countries (Germany, Switzerland, Austria)
8.	India
9.	Italy
10.	Japan
11.	Lebanon
12.	Mexico
13.	Nigeria
14.	Russian Federation
15.	South Africa
16.	Spain
17.	Tunisia
18.	U.S.A.

Status of the revision process

Formative Field Studies

In the formative field trials, several studies identified suggestions for disorders to be removed from the ICD-11 chapter on mental and behavioural disorders (most notably gender identity disorders and disorders of sexual dysfunctions [7]). A global survey of psychiatrists showed that there was a general trend to limit the number of categories to below 100, and to introduce dimensional and functional assessments [8]. In a survey among German-speaking psychiatrists, the participants identified neurasthenia as a mental disorder for omission, and suggested to differentiate dementias by their causes [9]. Among Chinese psychiatrists, an inclination towards stricter classification criteria was evident [10]. Indian psychiatrists supported a classification with many fewer categories, with nearly half inclined towards a system with 30 or fewer categories, but with substantial flexibility for cultural variation and clinical judgment [11]. A global survey of psychologists showed a tendency towards a more flexible use of diagnostic guidelines [12]. A survey among German-speaking psychologists showed that they argued for a flexible use and guidance towards strict criteria, and endorsed "dimensional" approaches [13]. In global surveys, mental health professionals showed comparatively similar taxonomies of the classification of mental disorders and their conceptualizations were also comparable between different professions [14, 15].

ICD-11 beta draft mental and behavioural disorders: metastructure

Table 3 provides an overview of the structures of the mental and behavioural disorders in ICD-10 and ICD-11. It shows that the number of sub-chapters has increased, in part because the artificial maximum of 10 grouping at each level created by the decimal structure of ICD-10 has been removed [2].

Table 3. **Groupings of mental and behavioural disorders in ICD-10 and ICD-11***

ICD-10**	ICD-11 beta draft, December 22, 2016***
F00-F09 Organic, including symptomatic, mental disorders F10-F19 Mental and behavioural disorders due to psychoactive substance use	Neurodevelopmental disorders
F20-F29 Schizophrenia, schizotypal and delusional disorders	Schizophrenia or other primary psychotic disorders
F30-F39 Mood (affective) disorders	Mood disorders
F40-F48 Neurotic, stress-related and somatoform disorders	Anxiety and fear-related disorders
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	Obsessive-compulsive or related disorders
F60-F69 Disorders of adult personality and behaviour	Disorders specifically associated with stress
F70-F79 Mental retardation	Dissociative disorders
F80-F89 Disorders of psychological development	Bodily distress disorder
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Feeding or eating disorders
F99-F99 Unspecified mental disorder	Elimination disorders
	Disorders due to substance use or addictive behaviours
	Impulse control disorders
	Disruptive behaviour or dissocial disorders
	Personality disorders and related traits
	Paraphilic disorders
	Factitious disorders
	Neurocognitive disorders
	Mental or behavioural disorders associated with pregnancy, childbirth and the puerperium, not elsewhere classified
	Psychological or behavioural factors affecting disorders or diseases classified elsewhere

table continued on the next page

	Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere
	Sleep-wake disorders
	Sexual dysfunctions
	Gender incongruence

*Note that some of these groupings (Sleep-wake disorders, Sexual dysfunctions, Gender incongruence, Symptoms, signs, and clinical findings) are actually in chapters outside MBD. Note that there are different versions of the ICD-11 beta draft online: The "foundation" version contains a listing of all available classification groups and diagnostic entities and is the basis of the ICD-11 beta draft column of this table. In the foundation version, some mental disorders may be listed in several groupings and therefore the foundation version does not list code numbers. There are also different "linearization" versions of ICD-11, and one of these is the already available "linearization" for morbidity and mortality statistics (http://apps.who.int/classifications/icd11/browse/l-m/en#/http://id.who.int/icd/entity/2055403635; retrieved: December 22, 2016). Only the latter lists every diagnostic entity only in one specific grouping and contains code numbers.

** http://apps.who.int/classifications/icd10/browse/2016/en

*** http://apps.who.int/classifications/icd11/browse/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentit%2f523677473

In addition, within these groupings, several reorganization steps have occurred, which can be summarized as follows (not that some of these groupings are in other chapters outside the chapter on mental and behavioural disorders). The F-codes designations here relate to the ICD-10 version:

- The major diagnostic groups F0 (organic mental disorders), F1 (substance-use disorders), F2 (schizophrenia and other primary psychotic disorders) and F6 (personality disorders) will be retained, but relabelled and their internal structures will be changed considerably. Mental disorders secondary to somatic disorders are classified in the chapter "Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere";
- F3 (mood disorders) will be retained under the same label, but considerable changes of definitions of mood disorders will be implemented;
- Mental disorders of the F4 group will be reallocated to new groups ("Anxiety and fear-related disorders", "Obsessive-compulsive and related disorders", "Disorders specifically associated with stress", "Dissociative disorders", "Bodily distress disorders");
- Mental disorders of the F5 group will be reallocated to new groups ("Feeding and eating disorders", "Sleep-wake disorders", "Sexual dysfunctions", "Substance use disorders");
- Some mental disorders of the F6 group will be reallocated to new groups ("Personality disorders", "Impulse control disorders", "Paraphilic disorders", "Gender incongruence", "Factitious disorders");

– The mental disorders of the F7, F8 and F9 groups will be reallocated to the groups of "Neurodevelopmental disorders", "Disruptive behaviour and dissocial disorders", "Anxiety and fear-related disorders", "Obsessive-compulsive and related disorders", "Feeding and eating disorders", "Elimination disorders". Of note, there will be no more special diagnostic group for mental and behavioural disorders with onset usually during childhood and adolescence (formerly F9). Rather, childhood forms of disorders related to other groupings will be allocated to the appropriate grouping, emphasising their developmental continuity (e.g., "Separation anxiety disorder" will be listed with "Anxiety and fear-related disorders" [16]);
– A new separate group of "Conditions related to sexual health" will be created and will not be part of the mental disorders chapter. The groupings of "Sexual dysfunctions" and "Gender incongruence" will be part of this new chapter [7]).

ICD-11 beta draft mental and behavioural disorders: Diagnostic groupings

The information contained in the following paragraphs is derived from the online version (foundation version) of the ICD-11 Beta draft as obtained on December 20, 2016, shortly after major revisions of the previous beta draft contents of this chapter had been implemented (http://apps.who.int/classifications/icd11/browse/f/en).

Neurodevelopmental disorders

This new chapter entitled "Neurodevelopmental disorders" will contain the following diagnostic groups (Table 4).

Table 4. **Diagnostic groups in the proposed ICD-11 chapter on neurodevelopmental disorders**

Number	Diagnostic groups
1.	Disorders of intellectual development
2.	Developmental speech and language disorders
3.	Autism spectrum disorder
4.	Developmental learning disorder
5.	Developmental motor coordination disorder
6.	Chronic developmental tic disorders
7.	Attention deficit hyperactivity disorder
8.	Stereotyped movement disorder
9.	Neurodevelopmental syndrome due to prenatal alcohol exposure

Thus, the diagnostic categories of the previous ICD-10 groupings of "Mental retardation" and "Disorders of psychological development" will be found in the grouping of "Neurodevelopmental disorders" in the ICD-11, which also includes some categories corresponding to disorders that were in other parts of the ICD-11, for example, "Attention deficit hyperactivity disorder" in the ICD-11 corresponds to "Hyperkinetic disorder" in the ICD-10, which was found in the ICD-10 grouping of "Behavioural and emotional disorders with onset usually occurring in childhood or adolescence". An important reconceptualisation was suggested for the previous mental retardation disorders, now included in this chapter as "Disorders of intellectual development" [17]. ICD-11 has included the broader diagnosis of Autism Spectrum Disorder, which combines the ICD-10 categories of childhood autism (F84.0), atypical autism (F84.1), and Asperger's syndrome (F84.5). Specifiers are provided for autism spectrum disorder to indicate the co-occurrence of impairments in general intellectual functioning and in functional language abilities (spoken or signed), which are important in guiding treatment selection

Schizophrenia and other primary psychotic disorders

In this chapter, the ICD-10 categories of "Schizophrenia", "Schizoaffective disorder", "Schizotypal disorder", "Acute and transient psychotic disorder" and "Delusional disorder" are included. A crosswalk to the "Secondary psychotic syndromes" is also mentioned here. This chapter will feature a range of changes from the previous ICD-10 categories with a view to improve the diagnostic clarity and utility of the mental disorders included in this group [18, 19]. In Schizophrenia, for example, the ICD-10 subtypes "paranoid", "hebephrenic" and "catatonic" will be omitted and the importance of the Schneiderian first rank symptoms will be deemphasised, since there was not sufficient evidence for their clinical utility and stability over time. To still be able to code the various clinical manifestation types of Schizophrenia, new symptom specifiers for primary psychotic disorders were introduced. These include specifiers for positive symptoms, negative symptoms, depression, mania, psychomotor symptoms, and cognitive symptoms. New course specifiers were also introduced. These differentiate between first and subsequent episodes of primary psychotic disorders, and chronic (non-episodic) course types. Among the acute episodes, a distinction will be possible between states of acute full-blown symptoms, partial remission and complete remission.

Other major changes include the redefinition of schizoaffective disorder as the temporal (simultaneous) co-occurrence of schizophrenia and a mood disorder, with a view to improve the clarity of the concept and exclusion of cases from this diagnostic group if they show alternating subsequent signs of schizophrenia and mood episodes without clear clinical temporal overlap. Another change is an improved delineation of acute and transient psychotic disorders with and without symptoms of schizophrenia in order to provide a clearer clinical distinction of the acute and transient types of

primary psychotic disorders without clinical signs and symptoms of schizophrenia as compared to the clinical picture of the acute clinical manifestations of schizophrenia.

Mood disorders

Mood disorders are characterised by "mood episodes" in ICD-11, which include depressive episode, manic episode and mixed episode. In ICD-11, unlike in ICD-10, these are not independently diagnosable entities, and therefore do not have their own diagnostic codes. They make up the primary components of most of the mood disorders. "Mood disorders" include "Bipolar and related disorders", "Depressive disorders" and "Secondary mood syndromes". The number and pattern of mood episodes over time is used to determine the appropriate "Mood disorders" category. Severity and course specifiers distinguish between mild, moderate and severe severity types, an indication of whether psychotic symptoms are present, and if the current disease state is in an acute episode or in partial or full remission. Specifiers for melancholia, the presence of significant anxiety symptoms, seasonal pattern, and perinatal onset are also included. Cyclothymic and dysthymic disorders are included as a part of the groupings of "Bipolar and related disorders" and "Depressive disorders", respectively. Another major change will be the addition of "Bipolar type II disorder", which is defined by the "occurrence of one or more hypomanic episodes and at least one depressive episode". The symptoms should not be severe enough to cause marked impairments of functioning.

Anxiety and fear-related disorders

This group will include nine subgroups of mental disorders (Table 5) (see [16]).

Table 5. **Anxiety and fear-related disorders as proposed for ICD-11**

Number	Diagnostic groups
1.	Generalised anxiety disorder
2.	Panic disorder
3.	Agoraphobia
4.	Specific phobia
5.	Social anxiety disorder
6.	Separation anxiety disorder
7.	Selective mutism
8.	Hypochondriasis
9.	Secondary anxiety syndrome Factors associated with fear

This will unite the previously separated categories of fear and anxiety-related disorders. “Mixed anxiety and depressive disorder” was moved to the “Mood disorders” grouping. “Separation anxiety disorder” was moved from ICD-10 “Emotional disorders with onset specific to childhood” and now explicitly also includes adult cases. “Generalised anxiety disorder” is no longer a disorder of exclusion and can co-occur with “Depressive disorder” if anxiety symptoms occur outside mood episodes. This and other co-occurrence rules were introduced because several previous hierarchical exclusion rules of ICD-10 were eliminated because of lack of empirical support. “Agoraphobia” in ICD-11 is reconceptualised as excessive fear of specific negative outcomes like panic attacks in situations where escape is difficult or help unavailable. and can be diagnosed in ICD-11 independently or together with “Panic disorder”. The ICD-10 category “Social phobias” is renamed “Social anxiety disorder”. A list of “Factors associated with fear” is included concern about of fear of medical treatment, a feared complaint without a diagnosis, fear of pregnancy and personal frightening experiences in childhood.

Obsessive-compulsive and related disorders

This group will include eight mental disorders (Table 6) (see [19]).

Table 6. **Obsessive-compulsive and related disorders suggested for inclusion in ICD-11**

Number	Types of disorders
1.	Obsessive-compulsive disorder
2.	Body dysmorphic disorder
3.	Olfactory reference disorder
4.	Hypochondriasis
5.	Hoarding disorder
6.	Body-focused repetitive behaviour disorders
7.	Tourette syndrome
8.	Secondary obsessive-compulsive or related syndrome

New disease entities will be introduced in this category in ICD-11: “Body dysmorphic disorder”, “Olfactory reference disorder”, “Hoarding disorder” and “Body-focused repetitive behaviour disorder” (which will include trichotillomania and excoriation disorder (skin picking disorder)). In “Obsessive-compulsive disorder” (OCD), obsessions will be defined more broadly and previous ICD-10 subtypes will be omitted. The co-occurrence of “Schizophrenia” or “Depression” together with “Obsessive-compulsive disorder” will be permitted in ICD-11. A specifier is provided to indicate the degree of insight present in individuals with these disorders regarding the veracity

of the thoughts or beliefs associated with the disorder. "Hypochondriasis" was moved from the ICD-10 grouping of "Somatoform disorders" to the ICD-11 grouping of "Obsessive-compulsive and related disorders" [20, 21].

Disorders specifically associated with stress

This category will include the following mental disorders in ICD-11 (Table 7) (see [22] for a review.

Table 7. **Disorders specifically associated with stress as suggested for inclusion in ICD-11**

Number	Types of disorders
1.	Post-traumatic stress disorder
2.	Complex post-traumatic stress disorder
3.	Prolonged grief disorder
4.	Adjustment disorder
5.	Reactive attachment disorder
6.	Disinhibited social engagement disorder

The concept of post-traumatic stress disorder (PTSD) will be narrower compared to ICD-10, so that the diagnosis will require the presence of three core symptoms: re-experiencing, avoidance, and perceptions of heightened current threat [22]. The introduction of a new complex PTSD category is proposed, which is characterised by the following clinical features in addition to the full clinical picture of PTSD (ICD-11 Beta draft online, December 20, 2016).

1) severe and pervasive problems in affect regulation;
2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and
3) persistent difficulties in sustaining relationships and in feeling close to others.

A new category of "Prolonged grief disorder" has also been recommended for inclusion in the ICD-11, with acute symptoms lasting for at least six months and "clearly exceeds expected social, cultural or religious norms for the individual's culture and context". Both aspects of prolonged duration and exceeding expected social norms must be met. Note that two mental disorders of early childhood ("Reactive attachment disorder" and "Disinhibited social engagement disorder", which develop between ages 1 and 5 years) are included in this grouping.

Dissociative disorders

This chapter will include a range of dissociative clinical conditions, many of which are new disorder categories (Table 8).

Table 8. **Dissociative disorders suggested for inclusion in ICD-11**

Number	Types of disorders
1.	Dissociative neurological symptom disorder
2.	Dissociative amnesia
3.	Depersonalization-derealization disorder
4.	Trance disorder
5.	Possession trance disorder
6.	Complex dissociative intrusion disorder
7.	Dissociative identity disorder
8.	Secondary dissociative syndrome

"Dissociative neurological symptom disorder" (formerly ICD-10 F06.5) is now differentiated into twelve subtypes depending on the predominant neurological symptom (like convulsions, speech, or paralysis etc.). "Trance disorder" is defined as "a single or episodic involuntary marked alteration in state of consciousness or loss of customary sense of personal identity, accompanied by a narrowing of awareness of immediate surroundings or unusually narrow and selective focus on environmental stimuli, together with a limitation of movements, postures, and speech to repetition of a small repertoire that is experienced as being outside the individual's control". This does not include trance states induced by drugs, medication or other disorders. The definition also includes a function criterion, in that social functioning must be impaired. "Complex dissociative intrusion disorder" and "Dissociative identity disorder" are the designations of distinguishable forms of "multiple personalities" disorders and also include a functional impairment as a necessary diagnostic feature.

Bodily distress disorder

This new broad category replaces the "Somatoform disorders" of ICD-10 and will unite a number of previous separate categories like somatization disorder, somatoform autonomic dysfunction and neurasthenia. Note that hypochondriasis is included among the "Obsessive-compulsive and related disorders" and not in the grouping of "Bodily distress disorders" [23]. The core clinical feature of the "Bodily distress disorder" is "the presence of bodily symptoms that are distressing to the individual and excessive attention directed toward the symptoms". Mild, moderate and severe forms are differentiated in ICD-11, but no subtypes are specified.

Feeding and eating disorders

This is a category with substantial changes compared to its predecessor in ICD-10 (ICD-10 F5 [24, 25]). It includes the following seven categories:

Table 9. **Feeding and eating disorders suggested for inclusion in ICD-11**

Number	Types of disorders
1.	Anorexia Nervosa
2.	Bulimia Nervosa
3.	Binge eating disorder
4.	Avoidant-restrictive food intake disorder
5.	Pica
6.	Rumination-regurgitation disorder
7.	Cyclic vomiting syndrome

Diagnostic requirements for anorexia nervosa and bulimia nervosa have been broadened somewhat. In anorexia nervosa, the amenorrhea criterion was removed and the underweight criterion was relaxed (now BMI <18.5, in ICD-10 BMI <17.5). The "fear of gaining weight" criterion was extended to include preoccupation with body weight or shape, food and nutrition, and persistent behaviours to reduce weight or increase energy expenditure. A minimal duration criterion of four weeks was introduced. New categories of binge eating disorder and avoidant-restrictive food intake disorder have been introduced. These changes are expected to reduce the rate of unspecified eating disorder diagnoses, the most common diagnoses in many settings. They also largely obviate the need for the ICD-10 categories of "atypical" anorexia nervosa and "atypical" bulimia nervosa, which have been removed in ICD-11. The non-specific ICD-10 category of feeding disorder of infancy or early childhood have been replaced by more specific categories that may also be diagnosed in older children as well as adolescents and adults.

Elimination disorders

This group contains "Enuresis and encopresis" as the sole entities. In both categories, cases are excluded if the elimination disorders are due to medical conditions.

Disorders due to substance use

The general structure of this chapter will introduce a distinction between disorders due to substance use and addictive behaviours.

Among the substance abuse disorders, new substances of abuse will be added: synthetic cannabinoids, anxiolytics, synthetic cathinones, MDMA, ketamine and

PCP. ICD-11 will allow a differentiation for each class of substances (with slight substance-specific alterations depending on the specific effects of each drug or drug class) as shown here for the alcohol-related disorders. The list will also include codes for different clinical aspects of substance use (Table 10).

Table 10. **Clinical aspects of disorders due to substance use suggested for ICD-11, using alcohol-related disorders as an example**

Number	Types of disorders
1.	Alcohol intoxication
2.	Harmful pattern of use of alcohol
3.	Alcohol dependence
4.	Alcohol withdrawal
5.	Alcohol-induced delirium
6.	Alcohol-induced psychotic disorder
7.	Alcohol-induced mood disorder
8.	Alcohol-induced anxiety disorder
9.	Alcohol-induced sexual dysfunction
10.	Alcohol-induced sleep disorder
11.	Dementia due to use of alcohol
12.	Amnestic disorder due to alcohol use
13.	Single episode of harmful use of alcohol

The "Addictive behaviour" subgroup now contains "Gambling disorder" and "Gaming disorder", the latter as a newly defined mental disorder "characterised by an impaired control over gaming, increasing priority given to gaming over other activities to the extent that gaming takes precedence over other interests and daily activities and continuation of gaming despite the occurrence of negative consequences". Significant psychosocial impairments must be present and a duration criterion of 12 months applies unless the symptoms are very severe, in which case the duration criterion may be shortened. Thus, ICD-11 introduces a type of internet-addiction disorder [26], which, however, also applies to excessive offline gaming habits.

Impulse control disorders

This group includes "Pyromania", "Kleptomania", "Compulsive sexual behaviour disorder" and "Intermittent explosive disorder". Initial suggestions to include "Gambling disorder" here were not implemented (they are found among the disorders of addictive behaviours [27, 28]). "Intermittent explosive disorder" is a new diagnostic entity defined as "repeated brief episodes of verbal or physical aggression or destruction of property that represent a failure to control aggressive impulses, with the intensity of

the outburst or degree of aggressiveness being grossly out of proportion to the provocation or precipitating psychosocial stressors" (ICD-11 beta draft online; last accessed December 20, 2016). "Compulsive sexual behaviour disorder" replaces "Excessive sexual drive" in ICD-10, and is characterised by a persistent pattern of failure to control intense sexual impulses or urges, resulting in failure to control repetitive sexual behaviour that is evident over an extended period of time (e.g., 12 months), and causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Its inclusion among the "Impulse control disorders" rather than among the "Sexual dysfunctions", as in ICD-10, implies that the failure to control impulses is the central aspect of the pathology, rather than an exclusive focus on the sexual content of the behaviour.

Disruptive behaviour and Dissocial disorders

This group only contains "Oppositional-defiant disorder" (ICD-10 F91.3) and a new category of "Conduct-dissocial disorder" (differentiated by onset in childhood vs. onset during adolescence, the border between the two defined as lying at 10 years of age). Further clinical subdifferentiations apply for both: "Oppositional-defiant disorder" with or without chronic irritability and anger, and limited vs. normal prosocial emotions in "Conduct-dissocial disorder". The ICD-11 approach towards the classification of children with severe irritability and anger is different from the DSM-5 approach, and a more extensive review of the evidence and the different classification options is given by Lochman et al. [29] and Evans et al. [30].

Personality disorders

For ICD-11, a dramatic reformulation of "Personality disorder" diagnoses has been proposed in response to well-established problems with their validity and application in clinical systems [31]. Under ICD-10 (and DSM-IV, which is the same as the classification in the main body of DSM-5), individuals with severe personality disorders generally meet the diagnostic requirements for several personality disorders. However, the categories are inconsistently applied in clinical settings, with borderline personality disorder frequently applied in mental health and general medical settings to describe difficult patients, and dissocial (or antisocial) personality disorder frequently applied in forensic contexts. As proposed for ICD-11, the primary dimension for the classification of personality disorder is severity, which may be mild, moderate, or severe. A subclinical level – personality difficulty – is also described but not classified as a mental disorder. Personality disorders may be described further by indicating the presence of characteristic maladaptive personality traits. Five trait domains that represent a set of dimensions that correspond to the underlying structure of personality traits are included: negative affectivity (the tendency to manifest distressing

emotions), dissociality (the tendency to disregard social conventions and the rights of others), disinhibition (the tendency to act impulsively), anankastia (the tendency to control one's own and other's behaviour), and detachment (the tendency to maintain emotional and interpersonal distance). As many of these trait domains may be noted as are judged to be both prominent and contributing to the personality disorder and its severity. The previous ICD-10 subtypes of personality disorders have been omitted.

Paraphilic disorders

Disorders of sexual preference will be renamed as "Paraphilic disorders" to reflect the current terminology in the scientific literature and in clinical practice. The "Paraphilic disorders" are characterised by patterns of atypical sexual arousal that focus on non-consenting others, as these conditions could be considered to have public health implications [7]. The "Paraphilic disorders" include "Exhibitionistic disorder", "Voyeuristic disorder", "Paedophilic disorder", "Coercive sexual sadism disorder", "Frotteuristic disorder", other paraphilic disorder involving non-consenting individuals and paraphilic disorder involving solitary behaviour or consenting individuals. The latter was introduced to include cases, in which "1) the person is markedly distressed by the nature of the arousal pattern and the distress is not simply a consequence of rejection or feared rejection of the arousal pattern by others; or 2) the nature of the paraphilic behaviour involves significant risk of injury or death either to the individual or to the partner (e.g., asphyxophilia)" (ICD-11 beta draft online; last accessed December 22, 2016). A detailed discussion of the arguments for excluding disorders of sexual orientation in ICD-11 can be found in a review of the WHO decision process related to this issue [32].

Factitious disorder

This group contains only two entities: "Factitious disorder imposed on the self" and "Factitious disorder imposed on another". In ICD-10, the former category is called "Intentional production or feigning of symptoms or disabilities, either physical or psychological" (F68.1). The latter category is newly introduced in ICD-11.

Neurocognitive disorders

This new group encompasses "Delirium", "Amnestic disorder", "Mild neurocognitive disorder" and "Dementia syndrome". "Dementia syndrome" may be classified at three levels of severity (mild, moderate, severe) and codes to identify different aetiologies of dementia are provided.

Mental or behavioural disorders associated with pregnancy, childbirth and the puerperium, not elsewhere classified

This is defined as "a syndrome associated with pregnancy or the puerperium (commencing within about 6 weeks after delivery) that involves significant mental and behavioural features but does not fulfil the diagnostic requirements of any of the specific mental and behavioural disorders" (ICD-11 beta draft online, last accessed December 22, 2016) and may be differentiated into clinical manifestations with or without psychotic symptoms.

Psychological or behavioural factors affecting disorders or diseases classified elsewhere

This is a free-standing entry in the chapter of "Mental and behavioural disorders" and includes the mental factors affecting disorders or diseases classified in other chapters of the ICD. ICD-11 states that this diagnosis should be used only when such factors increase the risk of suffering, disability, or death, represent a focus of clinical attention, and are not better explained by another mental and behavioural disorder (ICD-11 beta draft online, last accessed December 22, 2016). They may influence the course or treatment of the medical condition by constituting an additional health risk factor, by affecting treatment adherence or care seeking, or by influencing the underlying pathophysiology to precipitate or exacerbate symptoms or to necessitate medical attention.

Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere

This chapter lists "Secondary mental disorders" defined as "a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition […]" (ICD-11 beta draft online; last accessed December 22, 2016). The group includes "Secondary neurodevelopmental syndrome", "Secondary psychotic syndrome", "Secondary mood syndrome", "Secondary anxiety syndrome", "Secondary obsessive-compulsive or related syndrome", "Secondary dissociative syndrome", "Secondary impulse control syndrome", "Secondary neurocognitive syndrome", "Secondary personality change", and "Delirium" due to causes other than substances including medications.

Sexual dysfunctions

The grouping of "Sexual dysfunctions" is proposed for inclusion in a new ICD-11 chapter on conditions related to sexual health (chapter 17 in the current ICD-11 beta version). In ICD-10, so-called "organic" and "non-organic" sexual dysfunctions were in separate chapters, with the "non-organic" dysfunctions appearing in the chapter on "Mental and behavioural disorders". This mind-body separation is inconsistent with current evidence and more integrative clinical approaches, which view the origin and maintenance of sexual dysfunctions as frequently involving the interaction of physical and psychological factors [7]. In ICD-11, these categories have been brought together in a single grouping and have been substantially reorganised, along with a separate grouping of "Sexual pain disorders".

In addition, "Sexual dysfunctions" are cross-listed ("secondary parented") in the "Mental and behavioural disorders" chapter, given the frequent importance of psychological and behavioural factors in their origin and maintenance. "Multiple parenting" is a mechanism that has been introduced in ICD-11 that allows particular entities to appear in more than one location in order to improve the classifications utility for users. For example, tuberculosis meningitis would be listed in the chapter on infectious diseases as well as in the chapter on diseases of the nervous system so that a clinician or coder who was looking for the entity would be able to fund it through either route (much like it is possible to find the same book using multiple search strategies on Amazon). The alphanumeric code, indicating the "primary parent", remains constant even though the entity can be found in multiple locations. "Secondary parenting" also provides a clear message that "Sexual dysfunctions" are within the appropriate scope of practice of psychiatrists and other mental health professionals with appropriate training.

Gender incongruence

The grouping of "Gender incongruence" represents a substantial revision of the "Gender identity disorders" categories in ICD-10 (F64). This grouping is also recommended for placement in the chapter on conditions related to sexual health, and contains two categories: "Gender incongruence of adolescence and adulthood" and "Gender incongruence of childhood". These proposals have been the subject of considerable discussion in the literature [7, 33–35].

Sleep-wake disorders

As is the case for "Sexual dysfunctions", putatively "organic" and "non-organic" sleep disorders are listed in separate chapters in the ICD-10. The "organic" sleep disorders are mostly listed in the chapter on diseases of the nervous system, though some are listed elsewhere, such as in respiratory diseases. The "non-organic" sleep

disorders are listed in "Mental and behavioural disorders". In ICD-11, a new chapter on "Sleep-wake disorders" has been proposed, which brings together these entities in a single integrated classification that acknowledged the interaction of psychological, behavioural, and physical factors in their development and maintenance. This approach is more consistent with current research and practice. As is the case with "Sexual dysfunctions", "Sleep-wake disorders" are cross-listed ("secondary parented") in the "Mental and behavioural disorders" chapter, emphasising the importance of psychological and behavioural factors and also conveying that they may be evaluated and treated by psychiatrists and other mental health professionals with appropriate training. The major categories of "Sleep-wake disorders" proposed for ICD-11 are shown in Table 11. This classification is designed to be generally consistent with the Third Edition of the International Classification of Sleep Disorders [36], though is substantially simpler.

Table 11. **Sleep-wake disorders suggested for inclusion in ICD-11**

Number	Types of disorders
1.	Insomnia disorders
2.	Sleep-related movement disorders
3.	Hypersomnolence disorders
4.	Sleep-related breathing disorders
5.	Circadian rhythm sleep-wake disorders
6.	Parasomnia disorders
7.	Disorders of the sleep-wake schedule
8.	Certain specified sleep disorders

Mental and behavioural symptoms, signs, and clinical findings

This grouping is a part of the ICD-11 chapter on "Symptoms, signs, or clinical findings, not elsewhere classified" (Chapter 21). It contains a list of symptoms and signs, with definitions, that can be used to identify significant aspects of the clinical picture of a particular case, whether or not the individual is diagnosed with a mental disorder. The major classes of symptoms in this grouping are shown in Table 12. These symptom categories may be used to identify presenting symptoms in primary care settings or in individuals whose diagnostic evaluation has not been completed. They may also be used to identify specific symptoms that are directly relevant to clinical management that occur in the context of other health conditions, such as panic attacks that occur in the context of a life-threatening medical diagnosis or in the context of depression. This is a clinically relevant phenomenon that should be recorded, but typically does not justify an additional diagnosis of panic disorder.

Table 12. **Mental and behavioural symptoms, signs, and clinical findings in ICD-11 (listed outside the chapter on "Mental and behavioural Disorders" in the chapter "Symptoms, signs or clinical findings, not elsewhere classified")**

Number	Types of symptoms, signs, and clinical findings
1.	Symptoms, signs and clinical findings involving consciousness
2.	Symptoms, signs and clinical findings involving cognition
3.	Symptoms and signs involving motivation or energy
4.	Symptoms and signs involving appearance and behaviour
5.	Symptoms and signs involving mood or affect
6.	Symptoms and signs involving form of thought
7.	Symptoms and signs involving content of thought
8.	Symptom and signs involving perceptual disturbance
9.	Symptoms and signs related to personality features
10.	Symptoms and signs involving eating and related behaviour
11.	Symptoms and signs involving elimination
12.	Catatonia

Coding rules

ICD-11 will come in different "linearization" versions for specific coding purposes, and the first version available based on the "foundation" beta draft is a linearization for morbidity and mortality statistics (http://apps.who.int/classifications/icd11/browse/l-m/en#/; last accessed December 20, 2016). While the foundation version is a collection of all ICD-11 entities like diseases and represents the whole range of ICD-11 disorders, a linearization version is a subset of the foundation version fit for a particular purpose. In the linearization, each entity has a unique code and only occurs once in a specific diagnostic group ("single parenting"), while it may occur in multiple groups of the foundation version ("multiple parenting"). As an example, in the foundation version, dementias are listed both in the chapter on mental or behavioural disorders (parent group "Neurocognitive disorders") and in the chapter on diseases of the nervous system (parent group "Neurological disorders with neurocognitive impairment as a major feature"). Thus, in the foundation version, multiple parenting of the dementias puts them both into mental or behavioural disorders and disorders of the nervous system. In the linearization version, however, the dementias are to be coded uniquely ("single parenting") in the chapter of disorders of the nervous system (code 8A40 in the group of "Neurological disorders with neurocognitive impairment as a major feature"), but there is a crossreference to 8A40 in the list of mental or behavioural disorders (grouping "Neurocognitive disorders").

Given the historically inconsistent of the ICD-10 dagger and asterisk coding convention, ICD-11 will abolish the dagger/asterisk coding scheme previously used in ICD-10. Asterisk codes will become "clinical forms" or extension codes in ICD-11 (ICD-11 update, November 2015; http://www.who.int/classifications/icd/revision/18_dagger_asterisk _resolution.pdf?ua=1; http://www.who.int/classifications/icd/revision/2015_11_ICD11_News letter.pdf; retrieved: December 27, 2016) and further extension codes may indicate service contacts, episodes of care, course types, anatomic location etc. (also called "X"-chapter codes; http://ceur-ws.org/Vol-1515/poster12.pdf; retrieved: December 27, 2016). Furthermore, the new multiple parenting principle will make the dagger/asterisk coding convention redundant (WHO ICD Revision Information Note No. 18;). "Clustering indicators" may allow clustered coding of the cause of harm, the mode or mechanism of harm linked to each cause of harm, and the harm incurred, "clustering" a whole disease picture with a single number at the end of a complex, extended code figure, thus putting together the previous multiple codes into a single code ("clustering indicator"). This results in a restructured enhanced set of codes [37] and at the time of writing this review a preliminary coding tool was provided by WHO online (http://apps.who.int/classifications/icd11/ct/icd11beta_jlmms/en/2016-08-02#/; retrieved: December 22, 2016). As in ICD-10, exclusion and inclusion codes are indicated in both the foundation and linearization versions.

Table 13. **ICD-11 Beta draft linearization version for morbidity and mortality statistics: Classification code groups for the mental or behavioural disorders**

ICD-11 Code Group*	Grouping
06	Mental and behavioural disorders
6A0(x)**	Neurodevelopmental disorders
6A5(x), 6A6(x)	Schizophrenia or other primary psychotic disorders
6A7(x), 6A8(x), 6B0(x)	Mood disorders
6B1(x)	Anxiety and fear-related disorders
6B2(x)	Obsessive-compulsive or related disorders
6B3(x)	Disorders specifically associated with stress
6B4(x)	Dissociative disorders
6B5(x)	Bodily distress disorder
6B6(x)	Feeding or eating disorders
6B7(x)	Elimination disorders
6B8(x), 6B9(x), 6C0(x)-6C9(x), 6D0(x)-6D7(x)	Disorders due to substance use or addictive behaviours
6D8(x)	Impulse control disorders
6D9(x)	Disruptive behaviour or dissocial disorders

table continued on the next page

6E0(x), 6E1(x)	Personality disorders and related traits
6E2(x)	Paraphilic disorders
6E3(x)	Factitious disorders
6E4(x)	Neurocognitive disorders
6E5(x)	Mental or behavioural disorders associated with pregnancy, childbirth and the puerperium, not elsewhere classified
6E6(x)	Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere
6E8Y	Other specified mental or behavioural disorders
6E8Z	Mental or behavioural disorders, unspecified

* http://apps.who.int/classifications/icd11/browse/lm/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f696956921

** (x) is used here to indicate that further subcodes apply to the diagnostic entities contained in this grouping

Discussion

The proposed structure, categories, and definitions for ICD-11 mental and behavioural disorders are freely available online on the ICD-11 beta platform (http://apps.who.int/classifications/icd11/browse/f/en) and open for discussion and comment by registered users. In addition, WHO has established a global clinical practice network of nearly 13,000 international mental health and primary care professionals from more than 150 countries, called the Global Clinical Practice Network (GCPN). It is a network for those interested in participating in internet-based field studies or in obtaining more detailed information about the clinical and diagnostic guidelines, or other aspects of the revision process [4]. International interested readers can become members of this network by registering in any of nine languages at https://gcp.network. More detailed diagnostic guidelines for a number of mental and behavioural disorders groupings are available for review and comment by GCPN members on this internet platform, and additional guidelines will be posted in the coming months. Eventually, the more detailed guidelines will also be made available for public review.

As the experience with the formative field studies has shown, while there are differences in opinions about and usage of classification criteria for mental and behavioural disorders, there is still a core agreement about the necessity to construct a system that is clinically useful, appropriately flexible, and not overly complex. Currently, although there have been substantial simplifications in some of the areas reviewed above, the number of categories appears rather high in some areas such as “Disorders due to substance use”, and consideration of more streamlined presentations may be warranted. The introduction of symptom, course, and other specifiers in several areas appears to

be a reasonable method for introducing more "dimensional" constructs into the classification, but this also may increase the complexity of the overall system. Also, while some changes will perform timely revisions like the depathologisation of "disorders" of sexual orientation, other innovations may be more controversial and will require further evaluation in field studies. Some points remain to be clarified in future studies, such as the decision not to introduce an attenuated psychosis syndrome in ICD-11, which was introduced in DSM-5. A recent study showing that the DSM-5 research criteria for this syndrome may exclude some help-seeking persons from the healthcare process shows how difficult it may be to strike a balance between over-inclusive and under-inclusive clinical definitions of newly identified clinically important syndromes [38]. Thus, for this and other areas of the classification, future research may help to improve the current criteria by employing them in large scale clinical studies about case identification rates and ascertainment rates using additional criteria as "external validation" tools.

While the upcoming "clinical" field studies will provide important information about the clinical "ease of use" and goodness of fit of the proposed ICD-11 diagnostic guidelines in everyday clinical practice, intensified efforts are also necessary to improve the classification of mental disorders by elucidating the aetiopathogenesis of mental disorders and providing objective (neurobiological) assessment tools and procedures to aid in their diagnosis and to serve as "external validation" tools. Currently, complex pictures of disturbed neurocircuitry interacting with developmental, genetic and environmental factors are emerging and it is likely that highly sophisticated technologies will be necessary to make such findings useful for the clinical classification of mental disorders [19]. Until such sophisticated tools and methods are available, the clinical classifications provided by the ICD-11 chapter on mental and behavioural disorders will hopefully prove useful to identify persons who may need mental healthcare and provide a basis for national healthcare systems to provide the necessary services.

Conflicts of interest: *The authors declare that the preparation of this manuscript was not sponsored. The authors have no conflicts of interest regarding the contents of this review.*

References

1. 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.
2. 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: 82–90.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). Arlington: American Psychiatric Association Publishing; 2013.

4. Reed GM, Rebello TJ, Pike KM, Medina-Mora ME, Gureje O, Zhao M et al. *WHO's Global Clinical Practice Network for mental health*. Lancet Psychiat. 2015; 2: 379–380.
5. Keeley JW, Reed GM, Roberts MC, Evans SC, Medina-Mora ME, Robles R etal.. *Developing a science of clinical utility in diagnostic classification systems field study strategies for ICD-11 mental and behavioral disorders*. Am. Psychol. 2016; 71: 3–16.
6. 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 Psych. 2016; 16: 109–127.
7. 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: 205–221.
8. 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: 118–131.
9. Zielasek J, Freyberger HJ, Jänner M, Kapfhammer HP, Sartorius N, Stieglitz RD et al. *Assessing the opinions and experiences of German-speaking psychiatrists regarding necessary changes for the 11th revision of the mental disorders chapter of the International Classification of Disorders (ICD-11)*. Eur. Psychiat. 2010; 25: 437–442.
10. Dai Y, Yu X, Xiao Z, Xu Y, Zhao M, Correia JM et al. *Comparison of Chinese and international psychiatrists' views on classification of mental disorders*. Asia-Pac. Psychiat. 2014; 6: 267–273.
11. Avasthi A, Grover S, Maj M, Reed G, Thirunavukarasu M, Garg UC. *Indian Psychiatric Society – World Psychiatric Association – World Health Organization survey on usefulness of International Classification of Diseases – 10.* Indian Journal of Psychiatry 2014; 56: 350–358.
12. 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: 177–193.
13. Maercker A, Reed GM, Watts A, Lalor J, Perkonigg A. *What do psychologists think about classificatory diagnostics: the WHO-IUPsyS-survey in Germany and Switzerland in preparation for the ICD-11*. Psychother. Psych. Med. Psychol. 2014; 64: 315–321.
14. 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. Psychiatr. 2012; 24: 578–590.
15. 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: 1191–1212.
16. Kogan CS, Stein DJ, Maj M, First MB, Emmelkamp PMG, Reed GM. *The classification of anxiety and fear-related disorders in the ICD-11*. Depress. Anxiety 2016; 33: 1141–1154.
17. Bertelli MO, Munir K, Harris J, Salvador-Carulla L. *"Intellectual developmental disorders": reflections on the international consensus document for redefining "mental retardation-intellectual disability" in ICD-11*. Adv. Ment. Health Intellect. Disabil. 2016; 10: 36–58.
18. Gaebel W, Zielasek J, Cleveland HR. *Classifying psychosis-challenges and opportunities*. Int. Rev. Psychiatr. 2012; 24: 538–548.

19. Gaebel W, Zielasek J. *Schizophrenia in 2020: Trends in diagnosis and therapy*. Eur. Arch. Psych. Clin. N. 2015; 69: 661–673.

20. 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. Disorders 2016; 190: 663–674.

21. Simpson HB, Reddy YC. *Obsessive-compulsive disorder for ICD-11: proposed changes to the diagnostic guidelines and specifiers*. Rev. Bras. Psiquiatr. 2014; 36 Suppl. 1: 3–13.

22. Maercker A, Brewin CR, Bryant RA, Cloitre M, Ommeren M van, Jones LM et al. *Diagnosis and classification of disorders specifically associated with stress: proposals for ICD-11*. World Psychiatry 2013; 12: 198–206.

23. Gureje O. *Classification of somatic syndromes in ICD-11*. Curr. Opin. Psychiatr. 2015; 28: 345–349.

24. Uher R, Rutter M. *Classification of feeding and eating disorders: review of evidence and proposals for ICD-11*. World Psychiatry 2012; 11: 80–92.

25. Al-Adawi S, Bax B, Bryant-Waugh R, Claudino AM, Hay P, Monteleone P et al. *Revision of ICD – status update on feeding and eating disorders*. Advances in Eating Disorders: Theory, Research and Practice 2013; 1: 10–20.

26. Mann K, Fauth-Bühler M, Higuchi S, Potenza MN, Saunders JB. *Pathological gambling: A behavioral addiction*. World Psychiatry 2016; 15: 297–298.

27. Grant JE, Atmaca M, Fineberg NA, Fontenelle LF, Matsunaga H, Janardhan Reddy YC et al. *Impulse control disorders and "behavioural addictions" in the ICD-11*. World Psychiatry 2014; 13: 125–127.

28. Grant JE, Stein DJ. *Body-focused repetitive behavior disorders in ICD-11*. Rev. Bras. Psiquiatr. 2014; 36 Suppl. 1: 59–64.

29. Lochman JE, Evans SC, Burke JD, Roberts MC, Fite PJ, Reed GM et al. *An empirically based alternative to DSM-5's disruptive mood dysregulation disorder for ICD-11*. World Psychiatry 2015; 14: 30–33.

30. Evans SC, Burke JD, Roberts MC, Fite PJ, Lochman JE, Pena FR de la et al. *Irritability in child and adolescent psychopathology: An integrative review for ICD-11*. Clin. Psychol. Rev. 2017 (in press).

31. Tyrer P, Reed GM, Crawford MJ. *Classification, assessment, prevalence, and effect of personality disorder*. Lancet 2015; 385: 717–726.

32. Cochran SD, Drescher J, Kismödi E, Giami A, García-Moreno C, Atalla E et al. *Proposed declassification of disease categories related to sexual orientation in the International Statistical Classification of Diseases and Related Health Problems (ICD-11)*. B. World Health Organ. 2014; 92: 672–679.

33. Drescher J, Cohen-Kettenis P, Winter S. *Minding the body: Situating gender identity diagnoses in the ICD-11*. Int. Rev. Psychiatr. 2012; 24: 568–577.

34. Drescher J, Cohen-Kettenis PT, Reed GM. *Gender incongruence of childhood in the ICD-11: Controversies, proposal, and rationale*. Lancet Psychiat. 2016; 3: 297–304.

35. Robles R, Frésan A, Vega-Ramírez H, Cruz-Islas J, Rodríguez-Pérez V, Domínguez-Martínez T. *Removing transgender identity from the classification of mental disorders: A Mexican field study for ICD-11*. Lancet Psychiat. 2016; 3: 850–859.

36. American Academy of Sleep Medicine. *International Classification of Sleep Disorders*. 3rd ed. Darien, IL: American Academy of Sleep Medicine; 2014.

37. Ghali WA, Pincus HA, Southern DA, Brien SE, Romano PS, Burnand B et al. *ICD-11 for quality and safety: overview of the WHO quality and safety topic advisory group*. Int. J. Qual. Health C. 2013; 25: 621–625.

38. Schultze-Lutter F, Michel C, Ruhrmann S, Schimmelmann BG. *Prevalence and clinical significance of DSM-5-attenuated psychosis syndrome in adolescents and young adults in the general population: the Bern Epidemiological At-Risk (BEAR) study*. Schizophrenia Bull. 2014; 40: 1499–1508.

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