Draft diagnostic guidelines for ICD-11 mental and behavioural disorders available for review and comment

From the beginning, practicing psychiatrists and other mental health professionals around the globe have played an integral role in the development of the ICD-11 classification of mental and behavioural disorders by the World Health Organization (WHO) Department of Mental Health and Substance Abuse. A central aspect of practitioners' contribution has been their participation in a series of developmental field studies¹ conducted by the WHO to gather information about the performance of draft versions of the ICD-11 guidelines. Findings from these studies are being used to improve the reliability, validity and clinical utility of the final versions². As one specific example, data from a field study in which participants applied the proposed diagnostic guidelines for Disorders Specifically Associated with Stress to standardized case material in the form of vignettes showed that, while the ICD-11 guidelines were generally an improvement over ICD-10, clinicians did not clearly understand the new diagnostic requirement of re-experiencing for post-traumatic stress disorder and also found that the disorder was too narrowly defined³. Based on these results, specific changes were made to the diagnostic guidelines.

These field studies are currently being implemented via the Internet in multiple languages through the Global Clinical Practice Network (GCPN)⁴. The WHO Department of Mental Health and Substance Abuse established the GCPN as a realistic and feasible tool to collect truly global information about whether the proposed ICD-11 diagnostic guidelines lead to more accurate and consistent clinical decision-making than those of ICD-10. The GCPN was partly an extension of an earlier collaboration between the WHO and the WPA on a large international survey of nearly 5,000 psychiatrists in 44 countries regarding their use of and attitudes towards diagnostic classification systems⁵.

The GCPN now consists of more than 12,600 mental health and primary care professionals in nearly 150 countries. The largest group of GCPN participants – over half – are psychiatrists, followed by psychologists (29%). Nearly four in ten GCPN members are from low- and middle-income countries, where the large majority of the world's population lives.

The WHO's strong emphasis on participation by the anticipated daily users of the classification has sometimes been taken to suggest that we are managing the ICD-11 development as a popularity contest, making decisions about categories and diagnostic requirements based on whether or not practitioners "like" them. In fact, the proposals made by the ICD-11 Working Groups have been based on a careful consideration of the available scientific evidence. We believe that utility and validity are related and overlapping concepts⁶, and that a dichotomy between science and practice is false as applied to the approach we are taking to ICD-11 field studies.

But the WHO has also gone beyond traditional evidence reviews to develop a robust research agenda that treats the

extent to which the ICD-11 can be accurately and easily used by practitioners as a serious scientific question². For the WHO, the importance of clinical utility is closely related to the key aim of reducing the disease burden of mental and behavioural disorders and to the objectives of the WHO's Mental Health Action Plan of providing comprehensive, integrated and responsive mental health and social care services in community-based settings and strengthening information systems, evidence and research for mental health^{7,8}. If the ICD-11 is too cumbersome to use and fails to provide mental health professionals with clinically useful information, they simply won't apply it consistently. In that case, information collected at the health encounter level will not provide a valid basis for health policy or resource allocation at the system, national or global level.

Data collection is now beginning for multi-site ecological implementation field studies that will assess the clinical utility and diagnostic reliability of the ICD-11 guidelines in the global clinical settings in which they will ultimately be implemented. One arm of these clinic-based studies will involve the participation of major international field study centers. A second arm will provide the opportunity for GCPN members to contribute data regarding the implementation of the guidelines in the context of their own clinical practices.

The general proposed structure of the entire ICD-11, covering all health conditions, as well as brief glossary definitions for all categories are available for public review on the ICD-11 beta platform (<http://apps.who.int/classifications/icd11/browse/l-m/en>). Registered users may comment on the categories and definitions provided. However, the information available on the beta platform constitutes the statistical version of the classification, designed primarily for use by government health statistics agencies and coders of medical records and death statistics. The WHO does not consider this information to be sufficient for application of the ICD-11 by mental health professionals⁹. The latter is the purpose of the diagnostic guidelines.

Previously, we described the structure, nature and rationale for the ICD-11 diagnostic guidelines being developed for use by mental health professionals in global health care settings¹⁰. The complete guidelines are too lengthy to be practical for field studies, so an abbreviated version of the guidelines is being used for that purpose that consists of three core sections. *Essential features* provide explicit guidance regarding the symptoms or characteristics needed to confidently make the diagnosis. Their format is intended to conform to the way clinicians actually make psychiatric diagnosis, i.e., with the flexible exercise of clinical judgment. The field studies version of the guidelines also contains a section on *Boundary with other disorders and with normality*, which indicates those disorders that should be considered in the differential diagnosis and provides specific guidance related to each, as well as regarding the differentiation

from normal variation in characteristics that may underlie or be similar to the disorder. *Additional information* provides a description of other features that are relevant in helping the clinician to recognize variations in presentation of the disorder, but are not diagnostically determinative. The final, published version of the guidelines will include additional information (e.g., information on features related to culture, gender and development).

The WHO Department of Mental Health and Substance Abuse is interested in receiving comments on the proposed diagnostic guidelines from their intended users. To receive these comments, the Department has created a new Internet platform for members of the GCPN, called GCPNetwork (<http://gcp.network>). This platform will make several sets of guidelines available per month until all of them are included. All mental health or primary care professionals who are legally authorized to provide services to people with mental and behavioural disorders in their countries are eligible to join the GCPN and to provide comments on the proposed diagnostic guidelines. At a later time, the draft guidelines will also be made available for review by the general public.

A variety of additional resources for registered GCPN members are available at GCPNetwork. These include brief reports on the results of GCPN field studies, access to articles related to the development of ICD-11 mental and behavioural disorders, and a variety of relevant training resources. We invite you to visit <http://gcp.network>, to register if you are not already a member, to provide comments on the proposed ICD-11 guidelines, and to take advantage of the other resources we have and will continue to develop.

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1. First MB. *Lancet Psychiatry* (in press).
2. Keeley JW, Reed GM, Roberts MC et al. *Am Psychol* 2016;71:3-16.
3. Keeley JW, Reed GM, Roberts MC et al. *Int J Clin Hlth Psych* 2016;16:109-27.
4. Reed GM, Rebello TJ, Pike KM et al. *Lancet Psychiatry* 2015;2:379-80.
5. Reed GM, Mendonça Correia J, Esparza P et al. *World Psychiatry* 2011;10:118-31.
6. Maj M. *World Psychiatry* 2016;15:1-2.
7. Saxena S, Funk M, Chisholm D. *Lancet* 2013;381:1970-1.
8. Saxena S, Funk M, Chisholm D. *World Psychiatry* 2014;13:107-9.
9. World Health Organization. *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization, 1992.
10. First MB, Reed GM, Saxena S et al. *World Psychiatry* 2015;14:82-90.

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Can separation anxiety disorder escape its attachment to childhood?

The definition of separation anxiety disorder (SEPAD) has undergone significant changes in DSM-5, the most important being the lifting of the age restriction (18 years of age in DSM-IV) for assigning the diagnosis. There may be resistance, however, amongst some clinicians and researchers to extending the diagnosis to adulthood. We consider the arguments in favour and against this change in the hope of stimulating debate and research aimed at achieving a consensus on this issue.

Why do clinicians traditionally restrict the diagnosis of SEPAD to childhood (here used broadly to cover the period from infancy to early adolescence)? The main reason is that the construct of separation anxiety (SA) has long been central to developmental theories that exert a strong influence in guiding clinical practice. Within the broad developmental framework of psychoanalytic and attachment theories, SA is regarded as representing a repertoire of neurophysiological, intrapsychic and behavioural responses specifically designed to protect children from danger by ensuring the maintenance of close proximity to an adult caregiver, typically the mother. The SA mechanism is of particular importance to our species because of the prolonged period of dependency of the child on the caregiver¹. In

attachment theory, heightened expressions of SA are regarded as indicating disturbances in the child's working models or internal representations of attachment figures, shaped by past and ongoing bonding experiences with primary caretakers². SEPAD as a diagnosis therefore lies at the extreme end of a spectrum of responses that extend from the normative to the pathological, its presence signifying that the child has been exposed to severe disruptions and/or disturbances in his/her primary bonds². Classical symptoms of SEPAD (excessive clinging, tantrums, school refusal, abdominal pain and headaches, refusal to sleep alone, and nightmares of being attacked or abducted) reinforce further the phase-specific nature of the response.

Yet attachment theory has long acknowledged that the drive to form and maintain close bonds is fundamental to humans throughout the life course³. The corollary must be that the SA response can occur in persons of all ages. Indeed, reciprocity in the SA response between the mother and the child is critical to the mechanism's protective function; by mirroring the alarm signals of the lost child, the mother's anxiety ensures that she engages in intensive searching behaviour to rescue the young person from potential harm. More generally, in collective species