

Status of Psychotic Disorders in ICD-11

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This editorial reflects the work of all of the members of the WHO Working Group on the Classification of Psychotic Disorders, which include Jonathan Burns (South Africa), Peter Falkai (Germany), Saeed Farooq (Pakistan), Wolfgang Gaebel, Chair (Germany), Silvana Galderisi (Italy), Philippa Garety (UK), Michael Green (USA), Assen Jablensky (Australia), Veronica Larach Walters (Chile), Toshimasa Maruta (Japan), and Pichet Udomratn (Thailand), assisted by WHO Secretariat members Geoffrey Reed and Shekhar Saxena and consultant Michael B. First. Jürgen Zielasek (Germany) is rapporteur for the Working Group. The views expressed in this editorial reflect the opinion of its author and, except as specifically noted, do not represent the official policies and positions of the Working Group, the Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, or of WHO.

The World Health Organization (WHO) is currently revising the International Classification of Disorders (ICD-10), which was approved in 1990, making the current period the longest in the history of the ICD without a major revision.¹ WHO is a global public health agency of the United Nations, whose constitutional responsibilities include the development and maintenance of international classification systems for health.² WHO's Member States have agreed by international treaty to use the ICD as a basis for reporting health information that is usable and comparable across countries.

Within the context of the overall ICD revision process, the WHO Department of Mental Health and Substance Abuse has been assigned responsibility for managing the technical work of developing the chapter on mental and behavioral disorders. In developing the ICD-11 classification of mental and behavioral disorders, the Department has specified that substantial changes to existing mental disorder categories and definitions should be made through a transparent, international, multidisciplinary, and multilingual process that involves the direct participation of a broad range of stakeholders and is as free as possible from conflicts of interests. To assist the Department in all phases of the mental and behavioral disorders revision process, the WHO has appointed an International Advisory Group, chaired by Steven E. Hyman, which has in turn appointed a series of Working Groups in specific areas.³ The Working Group on the Classification of Psychotic Disorders (WGPD), of which the first author is chair, has been charged with reviewing the evidence and developing proposals for schizophrenia spectrum and other primary psychotic disorders. The editorial is intended to provide an overview of the WGPD's progress, and it follows a similar

editorial on the classification of psychotic disorders in DSM-5.⁴

It is important to be aware that, in addition to differences in their purpose, organizational context, and constituencies, the time frames for ICD-11 and DSM-5 differ.⁵ ICD-11 is currently scheduled for presentation to the World Health Assembly, WHO's governing body, in 2015. The initial proposals for categories, structure or architecture, definitions and diagnostic guidelines on Mental and Behavioural Disorders will be published on the internet for public review and discussion by September 2012, together with the revision proposals for all other chapters of the ICD-11. The proposals will be revised in response to public comment and expert peer review, under the guidance of the WHO Advisory Group, followed by field trials.

Consistent with this timeline, the WGPD is still in the process of finalizing its proposals, which have not yet been approved by the Advisory Group. Nonetheless, several more or less fundamental changes from ICD-10 in the classification of psychotic disorders can be foreseen. The most significant recommendations that are being made on the basis of evidence review and WGPD consensus include the following:

- The ICD-10 section “F2 Schizophrenia, schizotypal and delusional disorders” will be renamed “Schizophrenia spectrum and other primary psychotic disorders.” The use of the term “primary” here could be debated, but the intention is to distinguish these disorders from nonprimary psychotic disorders. Psychotic symptoms occurring in mood disorders will be classified among the affective disorders.
- Accordingly, nonprimary (ie, “secondary”) psychotic disorders such as psychotic disorders in general medical

- conditions and psychotic disorders due to substance use or withdrawal will be placed in the sections (or “blocks”) of the Mental and Behavioural Disorders chapter corresponding to “Substance-induced disorders” and “Mental and behavioural disorders associated with disorders or diseases classified elsewhere.” However, the unique features of the ICD-11, including its fully relational and electronic development, make it possible to cross-list substance-induced psychotic disorders and those associated with general medical conditions in the block for psychotic disorders as well, enhancing clinical utility while still retaining the ability to allocate and aggregate these disorders appropriately for public health reporting.
- The overall structure being proposed for the ICD-11 block on “Schizophrenia spectrum and other primary psychotic disorders” is as follows:
 - Schizophrenia
 - Schizoaffective disorder
 - Acute and transient psychotic disorder (ATPD)
 - Schizotypal disorder
 - Delusional disorder
 - Other primary psychotic disorders
 - Unspecified primary psychotic disorders
 - Single disorders will continue to be categorized on the basis of their psychopathological profile and duration. As a part of the overall development of ICD-11 across all disease areas, each category is characterized by means of a “content form,” which covers descriptive areas such as category name, relationship to ICD-10, definition, diagnostic guidelines, functional properties, coded qualifiers (specifiers), assessment issues, and others.
 - For ICD-11 schizophrenia, the WGPD recommends, in accordance with DSM-5, that the 9 ICD-10 *subtypes*—paranoid, hebephrenic, catatonic, etc.—be omitted because of their longitudinal instability and prognostic invalidity.⁶ These would be replaced by a system of coded qualifiers (see below). Although de-emphasizing the importance of first-rank symptoms,⁷ a diagnosis of schizophrenia would require the presence of at least 2 out of 8 symptoms, including at least one core symptom. Core symptoms include delusions, thought insertion/thought withdrawal, hallucinations, and thought disorder. Symptoms should have been clearly present for most of the time during a period of at least 1 month. That is, after a thorough discussion of the relevant clinical and public health issues and an evaluation of the available evidence, the WGPD is recommending to keep the ICD-10 duration requirement of 4 weeks. If the symptom requirements but not yet the duration requirement for “Schizophrenia” are fulfilled, classification would be as “Unspecified primary psychotic disorder” until the duration requirement for schizophrenia is met.
 - The WGPD is recommending that in ICD-11 a diagnosis of “Schizoaffective disorder” should be made only when the definitional requirements of schizophrenia and of a mood disorder of moderate or severe degree are met simultaneously or within a few days of each other. The total duration requirement would be 4 weeks, including both mood and schizophrenic symptoms. The open question remains whether the diagnostic categories should include a “lifetime” or longitudinal diagnostic requirement, following the distinction of a “sequential” and a “concurrent” type of schizoaffective disorder.⁸ There is no evidence as to how a longitudinal criterion would affect cross-sectional inter-rater reliability, and it is unknown how reliably lifetime symptoms can be reported by patients or assessed by clinicians retrospectively. Therefore, the ICD-11 proposal does not include a longitudinal diagnostic requirement, but it continues to use a purely cross-sectional approach. Longitudinal characteristics can be coded using course qualifiers (see below).
 - For the ICD-10 category “ATPD,” the WGPD is recommending that the diagnostic focus be on its sudden onset, brief duration, and high variability/fluctuation of psychotic and affective symptoms (ie, “polymorphic” clinical presentation).⁹ For simplification and due to a lack of empirical support for the prognostic and therapeutic relevance of the distinctions made in ICD-10 among several subtypes of ATPD, the WGPD is recommending that the subcategory F23.0 (Acute polymorphic psychotic disorder without symptoms of schizophrenia) be retained as the clinical guideline for ATPD, and the delusional subtype (F23.3) be incorporated into the revised category “Delusional disorder.”
 - The WGPD is recommending that the present ICD-10 categories F 23.1 (Acute polymorphic psychotic disorder with symptoms of schizophrenia) and F 23.2 (Acute schizophrenia-like psychotic disorder) be collapsed into “Unspecified primary psychotic disorders” if duration of disorder is less than 4 weeks. If duration is more than 4 weeks, schizophrenia should be diagnosed. “Schizophreniform disorder” is not recommended to be introduced into ICD-11.
 - The concept and clinical picture of ATPD in ICD-11 are different from “Brief psychotic disorder” in DSM-5, which uses 4 of the 5 clinical symptom criteria of schizophrenia, but not of a polymorphic and fluctuating nature. Also, ATPD in ICD-11 as in ICD-10 allows up to 3 months of symptom duration compared to 1 month for brief psychotic disorder in DSM-5. The rationale for this longer duration of symptoms is that the modal duration of remitting psychoses with acute onset is 2–4 months.¹⁰
 - The WGPD is recommending that the ICD-10 categories F22 “Persistent delusional disorder,” F24 “Induced delusional disorder,” and F23.3 “Other acute predominantly delusional psychotic disorder” be collapsed into

a new single diagnostic category called “Delusional disorder,” in order to simplify the classification system.

- Conceptually, schizotypal disorder will remain largely unchanged in ICD-11 from ICD-10. The WGPD believes that it is appropriate that it be placed in this block as a validated part of the schizophrenia “spectrum,” which was also the rationale for its placement with psychotic disorders in ICD-10.
- Concerning the internationally hotly debated “Attenuated psychosis syndrome,”¹¹ the WGPD is not recommending that it be included in the Mental and Behavioural Disorders chapter of ICD-11 but is considering a recommendation that it be incorporated into either the ICD-11 chapter on “Factors influencing health status and encounters with health services” (Z) or the chapter on “Symptoms, signs and abnormal clinical and laboratory findings” (R). Both these chapters, in different ways, represent ways of capturing phenomena that are relevant to health services and may be the focus of clinical attention, but which are not in themselves considered to be disorders or diseases.
- The WGPD is considering a range of coded qualifiers related to symptoms, course, cognitive function and functional impairment that would be used mainly for schizophrenia and schizoaffective disorder. (Note that uncoded specifiers, such as are used in the *Diagnostic and Statistical Manual of Mental Disorders* [DSM], are not possible within the classification framework of the ICD,¹² so each level of each of these qualifiers would have to be assigned a unique code.) In principle, these coded qualifiers could also be used with other psychotic disorder categories, and some of them may also be appropriate for use with other entities in the Mental and Behavioural Disorders chapter. Coded qualifiers under discussion include:
 - *Symptom qualifiers*, including the presence of positive, negative, depressive, manic, and psychomotor symptoms. The psychomotor symptoms qualifier would include catatonia, and discussions are currently underway with the Working Group on the Classification of Mood and Anxiety Disorders about using a common psychomotor qualifier across psychotic and mood disorders. There is some controversy over whether catatonia should be considered as a separate category,^{13,14} but the WGPD is not recommending this for ICD-11.
 - *Course qualifiers* to allow a differentiation between first- and multiple-episode cases, between acute episode and full/partial remission, and between acute and insidious onset of (first) psychotic episodes due to different prognostic implications.¹⁵
 - A *cognitive qualifier* is being considered to provide more diagnostic and therapeutic attention to cognitive issues with respect to functional outcome.¹⁶
 - The WGPD is supportive of a qualifier for *functional impairment*, which would need to be consistent with

the framework of WHO’s *International Classification of Functioning, Disability and Health* (ICF). Moreover, the WGPD is debating whether functional impairment should be a mandatory component of the diagnosis of schizophrenia. As in ICD-10, WHO generally prefers a separate coding of function,¹⁷ unless it is necessary to invoke functioning in order to distinguish disorder from normality.³ The dissociation of functional impairments and psychosis-like symptoms in otherwise healthy persons and the lack of association of functional impairments and psychotic symptoms fulfilling the diagnostic criteria of schizophrenia argue against the inclusion of functional impairment as a mandatory diagnostic criterion.^{18–20} In contrast to ICD, DSM has typically used a “clinical significance criterion” of functional impairment, distress, or risk of harm as a threshold for all mental disorders. Consistent with this history, DSM-5 will maintain functional impairment in schizophrenia as a mandatory criterion.

Major public and expert input is expected to follow the publication of the ICD-11 draft proposals on the internet. As ICD-11 is used worldwide²¹ by a large range of health professionals, its definitions and diagnostic guidelines will not only have to be reliable (and valid) but also be useful and easy to use by different users in different clinical settings. The WHO WGPD looks forward to a lively exchange and collaboration with our international colleagues as we work to improve, expand, and test the recommendations described above.

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