ICD-11 DIAGNOSTIC GUIDELINES

Schizophrenia or Other Primary Psychotic Disorders

Note: This document contains a pre-publication version of the ICD-11 diagnostic guidelines for Schizophrenia or Other Primary Psychotic Disorders. There may be further edits to these guidelines prior to their publication.

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SCHIZOPHRENIA OR OTHER PRIMARY PSYCHOTIC DISORDERS

Schizophrenia or Other Primary Psychotic Disorders is a grouping of disorders characterized by significant impairments in reality testing and alterations in behaviour as manifested by symptoms such as delusions, hallucinations, formal thought disorder (typically manifested as disorganized speech), and disorganized behaviour. They may be accompanied by psychomotor disturbances and negative symptoms such as blunted or flat affect. These symptoms do not occur primarily as a result of substance use (e.g., Hallucinogen Intoxication) or another medical condition not classified under Mental, Behavioural or Neurodevelopmental Disorders (e.g., Huntington Disease). The disorders in this grouping are referred to as primary psychotic disorders because psychotic symptoms are their defining feature. Psychotic symptoms may also occur in the context of other mental disorders (e.g., in Mood Disorders or Dementia), but in these cases the symptoms occur alongside other characteristic features of those disorders. Whereas experiences of reality loss/distortion occur on a continuum and can be found throughout the population, disorders in this group represent patterns of symptoms and behaviours that occur with sufficient frequency and intensity to deviate from expected cultural or subcultural expectations.

Schizophrenia or Other Primary Psychotic Disorders include the following:

6A20 Schizophrenia
6A21 Schizoaffective Disorder
6A22 Schizotypal Disorder
6A23 Acute and Transient Psychotic Disorder
6A24 Delusional Disorder
6A2Y Other Specified Schizophrenia or Primary Psychotic Disorders

In the context of Schizotypal Disorder, symptoms may be substantially attenuated such that they may be characterized as eccentric or peculiar rather than overtly psychotic.

The categories in the grouping of Schizophrenia or Other Primary Psychotic Disorders should not be used to classify the expression of ideas, beliefs, or behaviours that are culturally sanctioned. Many religious or cultural practices worldwide incorporate experiences qualitatively similar in nature to the symptoms described for this grouping of disorders, and these should not be considered to be pathological.

General Cultural Considerations

- Beliefs vary across cultures such that those considered odd or unusual in one culture may be normative in another. For example, belief in witchcraft or supernatural forces, or fears that transgressing cultural norms can lead to misfortune, are typical in many cultures. Distress may be expressed in ways that may be misinterpreted as evidence of psychotic symptoms, such as pseudo-hallucinations and overvalued ideas or dissociative experiences related to trauma.
- In some cultures, distress due to social circumstances may be expressed in ways that can be misinterpreted as psychotic symptoms (e.g., overvalued ideas and pseudo-hallucinations) but that instead are considered normal for the person's subgroup.
- Symptom presentation of Schizophrenia or Other Primary Psychotic Disorders may vary across cultures. For example, the content and form of hallucinations (e.g., visual

hallucinations are more common in some cultural groups and in some countries) or delusions may be culturally derived, making it difficult to differentiate among culturally normal experiences, overvalued ideas, ideas of reference, and transient psychosis. For instance, in several cultures (e.g., Southern China, Latin America) it is common to expect the spirit of a deceased relative to visit the homes of living relatives soon after they die. Hearing, seeing, or interacting with this spirit may be reported without notable pathological sequelae. Clarifying the cultural meaning of these experiences can aid in understanding the diagnostic significance of the symptom presentation.

- Cultural mismatch between the individual and the clinician may complicate the evaluation of Schizophrenia or Other Primary Psychotic Disorders. Collateral information from family, community, religious, or cultural reference groups may help clarify the diagnosis.
- Ethnic minorities and migrants are more likely than those in the general population to receive a diagnosis of Schizophrenia or Other Primary Psychotic Disorder. This may be due to misdiagnosis or to greater risk of psychosis resulting from migration traumas, social isolation, minority and acculturative stress, discrimination, and victimization.
- Caution is advised when assessing psychotic symptoms through interpreters or in a second or third language because of the risk of misconstruing unfamiliar metaphors as delusions and natural defensiveness as paranoia or emotional blunting.

6A20 Schizophrenia

Essential (Required) Features:

- At least two of the following symptoms must be present (by the individual's report or through observation by the clinician or other informants) most of the time for a period of 1 month or more. At least one of the qualifying symptoms should be from item a) through d) below:

    a) Persistent delusions (e.g., grandiose delusions, delusions of reference, persecutory delusions).
    b) Persistent hallucinations (most commonly auditory, although they may be in any sensory modality).
    c) Disorganized thinking (formal thought disorder) (e.g., tangentiality and loose associations, irrelevant speech, neologisms). When severe, the person's speech may be so incoherent as to be incomprehensible ('word salad').
    d) Experiences of influence, passivity or control (i.e., the experience that one's feelings, impulses, actions or thoughts are not generated by oneself, are being placed in one's mind or withdrawn from one's mind by others, or that one's thoughts are being broadcast to others).
    e) Negative symptoms such as affective flattening, alogia or paucity of speech, avolition, asociality and anhedonia.
    f) Grossly disorganized behaviour that impedes goal-directed activity (e.g., behaviour that appears bizarre or purposeless, unpredictable or inappropriate emotional responses that interferes with the ability to organize behaviour.)
    g) Psychomotor disturbances such as catatonic restlessness or agitation, posturing, waxy flexibility, negativism, mutism, or stupor.

- The symptoms are not a manifestation of another medical condition (e.g., a brain tumour) and are not due to the effects of a substance or medication (e.g., corticosteroids) on the central nervous system, including withdrawal effects (e.g., from alcohol).

Course qualifiers for Schizophrenia:

The following qualifiers should be applied to identify the course of Schizophrenia, including whether the individual currently meets the diagnostic requirements of Schizophrenia or is in partial or full remission. Course qualifiers are also used to indicate whether the current episode is the first episode of Schizophrenia, whether there have been multiple such episodes, or whether symptoms have been continuous over an extended period of time.

6A20.0 Schizophrenia, first episode

- The first episode qualifier should be applied when the current or most recent episode is the first manifestation of Schizophrenia meeting all diagnostic requirements in terms of symptoms and duration. If there has been a previous episode of Schizophrenia or Schizoaffective Disorder, the 'multiple episodes' qualifier should be applied.

6A20.00 Schizophrenia, first episode, currently symptomatic

- All diagnostic requirements for Schizophrenia in terms of symptoms and duration are currently met, or have been met within the past 1 month.
- There have been no previous episodes of Schizophrenia or Schizoaffective Disorder.

Note: If the duration of the episode is more than 1 year, the 'continuous' qualifier may be used instead, depending on the clinical situation.

6A20.01 Schizophrenia, first episode, in partial remission

- The full diagnostic requirements for Schizophrenia have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been no previous episodes of Schizophrenia or Schizoaffective Disorder.

6A20.02 Schizophrenia, first episode, in full remission

- The full diagnostic requirements for Schizophrenia have not been met within the past month, and no clinically significant symptoms remain.
- There have been no previous episodes of Schizophrenia or Schizoaffective Disorder.

6A20 Schizophrenia, multiple episodes

- The multiple episodes qualifier should be applied when there has been a minimum of two episodes meeting all diagnostic requirements of Schizophrenia or Schizoaffective Disorder in terms of symptoms, with a period of partial or full remission between episodes lasting at least 3 months, and the current or most recent episode is Schizophrenia. Note that the 1-month duration requirement for the first episode does not necessarily need to be met for subsequent episodes. During the period of remission, the diagnostic requirements of Schizophrenia are either only partially fulfilled or absent.

6A20.10 Schizophrenia, multiple episodes, currently symptomatic

- All symptom requirements for Schizophrenia are currently met, or have been met within the past month. Note that the 1-month duration requirement for the first episode does not necessarily need to be met for subsequent episodes.
- There have been a minimum of two episodes of Schizophrenia or a previous episode of Schizoaffective Disorder, with a period of partial or full remission between episodes lasting at least 3 months.

6A20.11 Schizophrenia, multiple episodes, in partial remission

- The full diagnostic requirements for Schizophrenia have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been a minimum of two episodes of Schizophrenia or a previous episode of Schizoaffective Disorder, with a period of partial or full remission between episodes lasting at least 3 months.

6A20.12 Schizophrenia, multiple episodes, in full remission

- The full diagnostic requirements for Schizophrenia have not been met within the past month, and no clinically significant symptoms remain.
- There have been a minimum of two episodes of Schizophrenia or a previous episode of Schizoaffective Disorder, with a period of partial or full remission between episodes lasting at least 3 months.

6A20.2 Schizophrenia, continuous

- The continuous qualifier should be applied when symptoms fulfilling all diagnostic requirements of Schizophrenia have been present for almost all of the course of the disorder during the person's lifetime since its first onset, with periods of subthreshold symptoms being very brief relative to the overall course. In order to apply this qualifier to a first episode, the duration of Schizophrenia must be at least 1 year. In that case, the continuous qualifier should be applied instead of the first episode qualifier.

Additional Clinical Features:

- The onset of Schizophrenia may be acute, with serious disturbance apparent within a few days, or insidious, with a gradual development of signs and symptoms.
- A prodromal phase often precedes the onset of psychotic symptoms by weeks or months. The characteristic features of this phase often include loss of interest in work or social activities, neglect of personal appearance or hygiene, inversion of the sleep cycle and attenuated psychotic symptoms, accompanied by negative symptoms, anxiety/agitation or varying degrees of depressive symptoms.
- Between acute episodes there may be residual phases, which are similar phenomenologically to the prodromal phase.
- Schizophrenia is frequently associated with significant distress and significant impairment in personal, family, social, educational, occupational or other important areas of functioning. However, distress and psychosocial impairment are not requirements for a diagnosis of Schizophrenia.

Boundary with Normality (Threshold):

- Psychotic-like symptoms or unusual subjective experiences may occur in the general population, but these are usually fleeting in nature and are not accompanied by other symptoms of Schizophrenia or a deterioration in psychosocial functioning. In Schizophrenia, multiple persistent symptoms are present and are typically accompanied by impairment in cognitive functioning and other psychosocial problems.

Course Features:

- The course and onset of Schizophrenia is variable. Some experience exacerbations and remission of symptoms periodically throughout their lives, others a gradual worsening of symptoms, and a smaller proportion experience complete remission of symptoms.
- Positive symptoms tend to diminish naturally over time, whereas negative symptoms often persist and are closely tied to poorer prognosis. Cognitive symptoms also tend to be more persistent and when present are associated with ongoing functional impairment.
- Early-onset Schizophrenia is typically associated with a poorer prognosis whereas affective and social functioning are more likely to be preserved with later onset.

Developmental Presentations:

- Onset of fully symptomatic Schizophrenia before puberty is extremely rare and when it occurs it is often preceded by a decline in social and academic functioning, odd behaviour, and a change in affect observable during the prodromal phase. Childhood onset is also associated with a greater prevalence of delays in social, language or motor development and co-occurring Disorder of Intellectual Development or Developmental Learning Disorder.
- In children and young adolescents, auditory hallucinations most commonly occur as a single voice commenting on or commanding behaviour whereas in adults such hallucinations are more typically experienced as multiple conversing voices.
- In children and adolescents, it may be challenging to differentiate delusions and hallucinations from more developmentally typical phenomena (e.g., a ‘monster’ under the child’s bed, an imaginary friend), actual plausible life experiences (e.g., being teased

or bullied at school), and irrational or magical thinking common in childhood (e.g., that thinking about something will make it happen).

- Among children with Schizophrenia, negative symptoms, hallucinations, and disorganized thinking—including loose associations, illogical thinking, and paucity of speech—tend to be prominent features of the clinical presentation. Disorganized thinking and behaviour occur in a variety of disorders that are common in childhood (e.g., Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder), which should be considered before attributing the symptoms to the much less common childhood Schizophrenia.

Culture-Related Features:

- Cultural factors may influence the onset, symptom pattern, course, and outcome of Schizophrenia. For example, among migrants and ethnic and cultural minorities, living in areas with a low proportion of their own ethnic, migrant or cultural group (low 'ethnic density') is associated with higher rates of Schizophrenia. In addition, etiological or course-related factors may be impacted by culture at the level of the family (e.g., level of family support, style of family interaction, such as expressed emotion) or at the societal level (e.g., industrialization, urbanization). For example, the prevalence of Schizophrenia is much higher in urban than rural settings.
- The risk of misdiagnosing the expression of distress as indicative of Schizophrenia or Other Primary Psychotic Disorder may be increased among ethnic minorities and immigrants, and in other situations in which the clinician is unfamiliar with culturally normative expressions of distress. These include situations involving spiritual or supernatural beliefs or resulting from migration trauma, social isolation, minority and acculturative stress, discrimination, and victimization.

Gender-Related Features:

- Schizophrenia is more prevalent among males.
- The age of onset of the first psychotic episode differs by gender with a greater proportion of males experiencing onset in their early to mid 20s and females in their late 20s.
- Females with Schizophrenia tend to report more positive symptoms that increase in severity over the course of their lives. Females also tend to have greater mood disturbance and a greater prevalence of subsequent or co-occurring mental disorders (e.g., Schizoaffective Disorder, Depressive Disorders).
- Females with Schizophrenia are less likely to exhibit disorganized thinking, negative symptoms, and social impairment.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Schizoaffective Disorder:*** The diagnoses of Schizophrenia and Schizoaffective Disorder are intended to apply to the current episode of the disorder. In other words, a previous diagnosis of Schizoaffective Disorder does not preclude a diagnosis of Schizophrenia, and vice versa. In both Schizophrenia and Schizoaffective Disorder, at least two the characteristic symptoms of Schizophrenia are present most of the time for a period of 1 month or more. In Schizoaffective Disorder, the symptoms of Schizophrenia are present concurrently with mood symptoms that meet the full diagnostic requirements of a Mood Episode and last for at least 1 month and the onset of

the psychotic and mood symptoms is either simultaneous or occurs within a few days of one another. In Schizophrenia, co-occurring mood symptoms, if any, either do not persist for as long as 1 month or are not of sufficient severity to meet the requirements of a Moderate or Severe Depressive Episode, a Manic Episode, or a Mixed Episode. (See Mood Episode Descriptions, p. _.) An episode that initially meets the diagnostic requirements for Schizoaffective Disorder in which only the mood symptoms remit, so that the duration of psychotic symptoms without mood symptoms is much longer than the duration of concurrent symptoms, may be best characterized as an episode of Schizophrenia..

- ***Boundary with Acute and Transient Psychotic Disorder:*** The psychotic symptoms in Schizophrenia persist for at least 1 month in their full, florid form. In contrast, the symptoms in Acute and Transient Psychotic Disorder tend to fluctuate rapidly in intensity and type across time, such that the content and focus of delusions or hallucinations often shift, even on a daily basis. Such rapid shifts would be unusual in Schizophrenia. Negative symptoms are often present in Schizophrenia, but do not occur in Acute and Transient Psychotic Disorder. The duration of Acute and Transient Psychotic Disorder does not exceed 3 months, and most often lasts from a few days to 1 month, as compared to a much longer typical course for Schizophrenia. In cases that meet the diagnostic requirements for Schizophrenia except that they have lasted less than the duration required for a diagnosis (i.e., 1 month) in the absence of a previous history of Schizophrenia, a diagnosis of Other Primary Psychotic Disorder and not Acute and Transient Psychotic Disorder should be assigned.
- ***Boundary with Schizotypal Disorder:*** Schizotypal Disorder is characterized by an enduring pattern of unusual speech, perceptions, beliefs and behaviours that resemble attenuated forms of the defining symptoms of Schizophrenia. Schizophrenia is differentiated from Schizotypal Disorder based entirely on the intensity of the symptoms; Schizophrenia is diagnosed if the symptoms are sufficiently intense to meet diagnostic requirements.
- ***Boundary with Delusional Disorder:*** Both Schizophrenia and Delusional Disorder may be characterized by persistent delusions. If other features are present that meet the diagnostic requirements of Schizophrenia (i.e., persistent hallucinations; disorganized thinking; experiences of influence, passivity, or control; negative symptoms; disorganized or abnormal psychomotor behaviour), a diagnosis of Schizophrenia should be made instead of a diagnosis of Delusional Disorder. However, hallucinations that are consistent with the content of the delusions and do not occur persistently (i.e., with regular frequency for 1 month or longer) are consistent with a diagnosis of Delusional Disorder rather than Schizophrenia. Delusional Disorder is generally characterized by relatively preserved personality and less deterioration and impairment in social and occupational functioning in comparison with Schizophrenia, and individuals with Delusional Disorder tend to come to clinical attention for the first time at a later age. Individuals with symptom presentations consistent with Delusional Disorder (e.g., delusions and related, circumscribed hallucinations) but who have not met the minimum duration requirement of 3 months should not be assigned a diagnosis of Schizophrenia even though the combination of persistent delusions and related hallucinations technically meets diagnostic requirements for Schizophrenia. Instead, a diagnosis of Other Primary Psychotic Disorder is more appropriate in such cases.
- ***Boundary with Moderate or Severe Depressive Episodes in Single Episode Depressive Disorder, Recurrent Depressive Disorder, Bipolar Type I Disorder, and Bipolar Type II Disorder:*** Psychotic symptoms may also occur during Moderate or Severe Depressive

Episodes. Delusions during Depressive Episodes may resemble delusions observed in Schizophrenia and are commonly persecutory or self-referential (e.g., being pursued by authorities because of imaginary crimes). Delusions of guilt (e.g., falsely blaming oneself for wrongdoings), poverty (e.g., of being bankrupt) or impending disaster (perceived to have been brought on by the individual), as well as somatic delusions (e.g., of having contracted some serious disease) and nihilistic delusions (e.g., believing body organs do not exist) are also known to occur. Experiences of passivity, influence or control (e.g., thought insertion, thought withdrawal, or thought broadcasting) may also occur in Moderate or Severe Depressive Episodes. Hallucinations are usually transient and rarely occur in the absence of delusions. Auditory hallucinations (e.g., derogatory or accusatory voices that berate the individual for imaginary weaknesses or sins) are more common than visual (e.g., visions of death or destruction) or olfactory hallucinations (e.g., the smell of rotting flesh). However, in a Moderate or Severe Depressive Episode with psychotic symptoms, the psychotic symptoms are confined to the Mood Episode. Schizophrenia is differentiated from Depressive Episodes in Mood Disorders by the occurrence of psychotic and other symptoms that meet the diagnostic requirements of Schizophrenia during periods without mood symptoms that meet the diagnostic requirements of a Moderate or Severe Depressive Episode. If the diagnostic requirements for both Schizophrenia and a Moderate or Severe Depressive Episode are met concurrently and both the psychotic and mood symptoms last for at least 1 month, Schizoaffective Disorder is the appropriate diagnosis.

- ***Boundary with Manic or Mixed Episodes in Bipolar Type I Disorder:*** Psychotic symptoms may occur during Manic or Mixed Episodes in Bipolar Type I Disorder. Though all types of psychotic symptoms are known to occur in Manic or Mixed Episodes, grandiose delusions (e.g., being chosen by God, having special powers or abilities), and persecutory and self-referential delusions (e.g., being conspired against because of one's special identity or abilities) are among the most common. Experiences of influence, passivity or control (e.g., thought insertion, thought withdrawal, or thought broadcasting) may also occur during Manic or Mixed Episodes. Hallucinations are less frequent and commonly accompany delusions of persecution or reference. They are usually auditory (e.g., adulatory voices), and less commonly visual (e.g., visions of deities), somatic, or tactile. However, in a Manic or Mixed Episode with psychotic symptoms, the psychotic symptoms are confined to the Mood Episode. Schizophrenia is differentiated from Manic or Mixed Episodes in Bipolar Type I Disorder by the occurrence of psychotic and other symptoms that meet the diagnostic requirements of Schizophrenia during periods without mood symptoms that meet the diagnostic requirements of a Manic or Mixed Episode. If the diagnostic requirements for both Schizophrenia and Bipolar Type I Disorder are met concurrently and both psychotic and mood symptoms last for at least 1 month, Schizoaffective Disorder is the appropriate diagnosis.
- ***Boundary with Post-Traumatic Stress Disorder and Complex Post-Traumatic Stress Disorder:*** In Post-Traumatic Stress Disorder and Complex Post-Traumatic Stress Disorder, severe flashbacks that involve a complete loss of awareness of present surroundings may occur, intrusive images or memories may have a hallucinatory quality, and hypervigilance may reach proportions that appear to be paranoid. However, the diagnoses of Post-Traumatic Stress Disorder and Complex Post-Traumatic Stress Disorder require a history of exposure to an event or series of events (either short- or long-lasting) of an extremely threatening or horrific nature. These diagnoses also require re-experiencing of the traumatic event in the present, in which the event is not just

remembered but rather experienced as occurring again in the here and now, and may include loss of awareness and hallucination-like experiences within this specific context. Re-experiencing of traumatic events is not a characteristic feature of Schizophrenia. However, Post-Traumatic Stress Disorder and Schizophrenia frequently co-occur, and both diagnoses should be assigned when the diagnostic requirements for each are met.

6A21 Schizoaffective Disorder

Essential (Required) Features:

- All diagnostic requirements for Schizophrenia are met concurrently with mood symptoms that meet the diagnostic requirements of a Moderate or Severe Depressive Episode, a Manic Episode, or a Mixed Episode. ***Note:*** In making a diagnosis of Schizoaffective Disorder, Depressive Episodes must include depressed mood, not just diminished interest or pleasure.
- The onset of the psychotic and mood symptoms is either simultaneous or occurs within a few days of one another.
- The duration of symptomatic episodes is at least 1 month for both psychotic and mood symptoms.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g., a brain tumour) and are not due to the effects of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal effects (e.g., from alcohol).

Course qualifiers for Schizoaffective Disorder:

The following qualifiers should be applied to identify the course of Schizoaffective Disorder, including whether the individual currently meets the diagnostic requirements of Schizoaffective Disorder or is in partial or full remission. Course qualifiers are also used to indicate whether the current episode is the first episode of Schizoaffective Disorder, whether there have been multiple such episodes, or whether symptoms have been continuous over an extended period of time.

6A21.0 Schizoaffective Disorder, first episode

- The first episode qualifier should be applied when the current or most recent episode is the first manifestation of the Schizoaffective Disorder meeting all diagnostic requirements in terms of symptoms and duration. If there has been a previous episode of Schizoaffective Disorder or Schizophrenia, the ‘multiple episodes’ qualifier should be applied.

6A21.00 Schizoaffective Disorder, first episode, currently symptomatic

- All diagnostic requirements for Schizoaffective Disorder in terms of symptoms and duration are currently met, or have been met within the past 1 month.
- There have been no previous episodes of Schizophrenia or Schizoaffective Disorder.

Note: If the duration of the episode is more than 1 year, the 'continuous' qualifier may be used instead, depending on the clinical situation.

6A21.01 Schizoaffective Disorder, first episode, in partial remission

- The full diagnostic requirements for Schizoaffective Disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been no previous episodes of Schizophrenia or Schizoaffective Disorder.

6A21.02 Schizoaffective Disorder, first episode, in full remission

- The full diagnostic requirements for Schizoaffective Disorder have not been met within the past month, and no clinically significant symptoms remain.
- There have been no previous episodes of Schizophrenia or Schizoaffective Disorder.

6A21.1 Schizoaffective Disorder, multiple episodes

- The multiple episodes qualifier should be applied when there has been a minimum of two episodes meeting all diagnostic requirements of Schizoaffective Disorder or Schizophrenia in terms of symptoms, with a period of partial or full remission between episodes lasting at least 3 months, and the current or most recent episode is Schizoaffective Disorder. Note that the 1-month duration requirement for the first episode does not necessarily need to be met for subsequent episodes. During the period of remission, the diagnostic requirements of Schizoaffective Disorder are either only partially fulfilled or absent.

6A21.10 Schizoaffective Disorder, multiple episodes, currently symptomatic

- All symptom requirements for Schizoaffective Disorder are currently met, or have been met within the past 1 month. Note that the 1-month duration requirement for the first episode does not necessarily need to be met for subsequent episodes.
- There have been a minimum of two episodes of Schizoaffective Disorder or a previous episode of Schizophrenia, with a period of partial or full remission between episodes lasting at least 3 months.

6A21.11 Schizoaffective Disorder, multiple episodes, in partial remission

- The full diagnostic requirements for Schizoaffective Disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been a minimum of two episodes of Schizoaffective Disorder or a previous episode of Schizophrenia, with a period of partial or full remission between episodes lasting at least 3 months.

6A21.12 Schizoaffective Disorder, multiple episodes, in full remission

- The full diagnostic requirements for Schizoaffective Disorder have not been met within the past month, and no clinically significant symptoms remain.
- There have been a minimum of two episodes of Schizoaffective Disorder or a previous episode of Schizophrenia, with a period of partial or full remission between episodes lasting at least 3 months.

6A21.2 Schizoaffective Disorder, continuous

- The continuous qualifier should be applied when symptoms fulfilling all diagnostic requirements of Schizoaffective Disorder have been present for almost all of the course of the disorder during the person's lifetime since its first onset, with periods of subthreshold symptoms being very brief relative to the overall course. In order to apply this qualifier to a first episode, the duration of Schizoaffective Disorder must be at least 1 year. In that case, the continuous qualifier should be applied instead of the first episode qualifier.

Additional Clinical Features:

- The onset of Schizoaffective Disorder may be acute, with serious disturbance apparent within a few days, or insidious, with a gradual development of signs and symptoms.
- There is often a history of prior Mood Episodes and a previous diagnosis of a Depressive Disorder or a Bipolar Disorder in individuals with Schizoaffective Disorder.
- A prodromal phase often precedes the onset of psychotic symptoms by weeks or months. The characteristic features of this phase often include loss of interest in work or social activities, neglect of personal appearance or hygiene, inversion of the sleep cycle and attenuated psychotic symptoms, accompanied by negative symptoms, anxiety/agitation, and varying degrees of depressive symptoms.
- An episodic course with periods of remission is the most common pattern of progression of the disorder.
- Schizoaffective Disorder is frequently associated with significant distress and significant impairment in personal, family, social, educational, occupational or other important areas of functioning. However, distress and psychosocial impairment are not requirements for a diagnosis of Schizoaffective Disorder.

Boundary with Normality (Threshold):

- Psychotic-like symptoms or unusual subjective experiences may occur in the general population, but these are usually fleeting in nature and are not accompanied by other symptoms of Schizophrenia or a deterioration in psychosocial functioning. In Schizoaffective Disorder, multiple persistent symptoms are present and are typically accompanied by impairment in cognitive functioning and other psychosocial problems.

Course Features:

- Some people with Schizoaffective Disorder experience exacerbations and remission of symptoms periodically throughout the illness course, whereas others experience a full remission of symptoms between episodes.

Developmental Presentations:

- Diagnosis of Schizoaffective Disorder among children is challenging because the sequence of mood and psychotic symptoms may be difficult for children to accurately describe.
- Children who are diagnosed with Schizoaffective Disorder are the most severely impaired and have the poorest outcomes amongst all children diagnosed with psychotic disorders.
- Schizoaffective Disorder with Manic Episodes is more common among young adults whereas Schizoaffective Disorder with Depressive Episodes is more common among older adults.

Culture-Related Features:

- See Culture-Related Features section for Schizophrenia, all of which also applies to Schizoaffective Disorder.
- In addition. culture may affect the expression of mood symptoms, the use of idioms of distress and illness-related metaphors, and the prominence of certain patterns of mood-related symptoms. For example, religious or spiritual views about suicidal ideation or behaviour may decrease reporting and increase associated guilt; and shame may be more prominent than guilt in sociocentric societies. Norms for experiencing and articulating mood symptoms psychologically vary by culture, as does the attribution of distress to interpersonal, social, psychological, biological, supernatural or spiritual concerns.
- Bodily complaints as somatic expressions of depression may predominate over cognitive mood symptoms due to their greater cultural acceptability as indications of the need for clinical attention.

Gender-Related Features:

- Schizoaffective Disorder is more prevalent among females than males, especially Schizoaffective Disorder with Depressive Episodes.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Schizophrenia:*** The diagnoses of Schizophrenia and Schizoaffective Disorder are intended to apply to the current or most recent episode of the disorder. In other words, a previous diagnosis of Schizoaffective Disorder does not preclude a diagnosis of Schizophrenia, and vice versa. In both Schizophrenia and Schizoaffective Disorder, at least two the characteristic symptoms of Schizophrenia are present most of the time for a period of 1 month or more. In Schizoaffective Disorder, the symptoms of Schizophrenia are present concurrently with mood symptoms that meet the full diagnostic requirements of a Mood Episode and last for at least 1 month and the onset of the psychotic and mood symptoms is either simultaneous or occurs within a few days of one another. In Schizophrenia, co-occurring mood symptoms, if any, either do not persist for as long as 1 month or are not of sufficient severity to meet the requirements of a Moderate or Severe Depressive Episode, a Manic Episode, or a Mixed Episode. (See Mood Episode Descriptions, p. _.) An episode that initially meets the diagnostic requirements for Schizoaffective Disorder in which only the mood symptoms remit, so

that the duration of psychotic symptoms without mood symptoms is much longer than the duration of concurrent symptoms, may be best characterized as an episode of Schizophrenia.

- ***Boundary with Mood Episodes with psychotic symptoms:*** Schizoaffective Disorder, Schizophrenia, Moderate or Severe Depressive Episodes, Manic Episodes, and Mixed Episodes are all intended to describe the current episode of the disorder. In Schizoaffective Disorder, the duration and symptom requirements for Schizophrenia are fully met during the Mood Episode. In a Depressive Disorder with psychotic symptoms or a Bipolar Type I Disorder with psychotic symptoms, psychotic symptoms occur simultaneously with the Mood Episodes but do not meet the diagnostic requirements for Schizophrenia (e.g., hallucinations without any other psychotic symptoms). It is possible for an individual to meet the diagnostic requirements for each during different periods. However, both a diagnosis of Schizoaffective Disorder and a diagnosis of a Depressive Disorder or Bipolar Type I Disorder should not be assigned based on the same episode.
- ***Boundary with Acute and Transient Psychotic Disorder:*** In Schizoaffective Disorder, the psychotic symptoms persist for at least 1 month in their full, florid form. In contrast, in Acute and Transient Psychotic Disorder, the symptom criteria for Schizophrenia or a Depressive, Manic or Mixed Episode are not met. Moreover, the symptoms in Acute and Transient Psychotic Disorder tend to fluctuate rapidly in intensity and type across time, such that the content and focus of delusions or hallucinations often shift, even on a daily basis. Negative symptoms may be present in Schizoaffective Disorder, but do not occur in Acute Transient Psychotic Disorder. The duration of Acute and Transient Psychotic Disorder does not exceed 3 months, and most often lasts from a few days to 1 month, as compared to a much longer typical course for Schizoaffective Disorder.

6A22 Schizotypal Disorder

Essential (Required) Features:

- An enduring pattern of unusual speech, perceptions, beliefs and behaviours that are not of sufficient intensity or duration to meet the diagnostic requirements of Schizophrenia, Schizoaffective Disorder, or Delusional Disorder. The pattern includes several of the following symptoms:
    - Constricted affect, such that the individual appears cold and aloof;
    - Behaviour or appearance that is odd, eccentric, unusual, or peculiar and is inconsistent with cultural or subcultural norms;
    - Poor rapport with others and a tendency towards social withdrawal;
    - Unusual beliefs or magical thinking influencing the person's behaviour in ways that are inconsistent with subcultural norms, but not reaching the diagnostic requirements for a delusion;
    - Unusual perceptual distortions such as intense illusions, depersonalization, derealization, or auditory or other hallucinations;
    - Suspiciousness or paranoid ideas;
    - Vague, circumstantial, metaphorical, overelaborate, or stereotyped thinking, manifest in odd speech without gross incoherence;
    - Obsessive ruminations without a sense that the obsession is foreign or unwanted, often with body dysmorphic, sexual, or aggressive content.

- Has never met the diagnostic requirements for Schizophrenia, Schizoaffective Disorder, or Delusional Disorder. That is, transient delusions, hallucinations, formal thought disorder, or experiences of influence, passivity or control may occur, but do not last for more than 1 month.
- Symptoms should have been present, continuously or episodically, for at least 2 years.
- The symptoms cause distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.
- The symptoms are not a manifestation of another medical condition (e.g., a brain tumour), are not due to the effects of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal effects (e.g., from alcohol), and are not better accounted for by another Mental, Behavioural, or Neurodevelopmental Disorder.

Additional Clinical Features:

- Schizotypal Disorder is more common in biological relatives of persons with a diagnosis of Schizophrenia and is considered to be a part of the spectrum of Schizophrenia-related psychopathology. Having a first-degree relative with Schizophrenia gives additional weight to a diagnosis of Schizotypal Disorder but is not a requirement if the individual is experiencing distress or impairment in psychosocial functioning related to their symptoms.

Boundary with Normality (Threshold):

- The threshold between symptoms of Schizotypal Disorder and extravagant, eccentric, or unusual behaviour and beliefs in individuals without a diagnosable disorder is sometimes difficult to determine, especially as some people in the general population show eccentric behaviour and report psychotic-like or unusual subjective experiences without any apparent impairment in functioning. Schizotypal Disorder should only be diagnosed if the individual is experiencing distress or impairment in personal, family, social, educational, occupational or other important areas of functioning related to their symptoms.

Course Features:

- The course of Schizotypal Disorder is relatively stable and chronic, with some fluctuation in symptom intensity. Individuals often have severe functional impairments in academic, occupational, and interpersonal domains.
- The symptoms of Schizotypal Disorder are typically present prior to full symptomatic onset:
    - Poor rapport with others and a tendency towards social withdrawal, suspiciousness or paranoid ideas; and
    - Vague, circumstantial, metaphorical, overelaborate, or stereotyped thinking, manifested in odd speech without gross incoherence.
- The disorder may persist over years with fluctuations of intensity and symptom expression but rarely evolves into Schizophrenia.
- Affected individuals typically seek treatment for comorbid Depressive or Anxiety or Fear-Related Disorders. Although intervention has demonstrated some efficacy in improving mood and anxiety symptoms, suspicion and paranoia often persist.

Developmental Presentations:

- Schizotypal Disorder typically begins in late adolescence or early adulthood, without a definite age of onset.
- Some symptoms of Schizotypal Disorder may first appear in childhood and adolescence affecting peer relationships and academic performance.

Cultural Presentation:

- A person's behaviour, appearance, speech, or illness explanations may appear odd or unusual to clinicians who are unfamiliar with the person's culture, but in the context of the person's cultural group may be either normative or not be sufficiently severe as to reach the threshold of a mental disorder. Concepts and experiences that are common in some cultures include witchcraft or sorcery, speaking in tongues, life beyond death, shamanism, mind reading, sixth sense, evil eye, spirit possession, and magical beliefs related to health and illness.
- Reduced engagement in interpersonal relationships may be part of some cultural or religious practices (e.g., monastic isolation) and should not be considered pathological.

Gender-Related Features:

- Schizotypal Disorder is slightly more common in males.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Schizophrenia:*** In the prodromal and residual phases of Schizophrenia, the individual may experience extended periods of perceptual distortions, unusual beliefs, odd or digressive speech, social withdrawal, and other symptoms that are characteristic of Schizotypal Disorder. A diagnosis of Schizophrenia, however, requires a period of at least 1 month of psychotic symptoms, in contrast to Schizotypal Disorder, which requires that any psychotic-like symptoms not meet the diagnostic requirements for Schizophrenia in terms of severity or duration. Moreover, the pattern of unusual speech, perceptions, beliefs and behaviours tends to be stable over time—even over years—in individuals with Schizotypal Disorder, in contrast to an evolving symptom picture either in prodromal or residual phases of Schizophrenia.
- ***Boundary with Autism Spectrum Disorder:*** Interpersonal difficulties seen in Schizotypal Disorder may share some features of Autism Spectrum Disorder, including poor rapport with others and social withdrawal. However, individuals with Schizotypal Disorder do not exhibit restricted, repetitive and stereotyped patterns of behaviour, interests, or activities.
- ***Boundary with Personality Disorder:*** Personality Disorder is defined as an enduring disturbance in the individual's way of interpreting and experiencing himself or herself, others, and the world that result in maladaptive patterns of emotional expression and behaviour, and produce significant problems in functioning that are particularly evident in interpersonal relationships. Individuals with Schizotypal Disorder should not be given an additional diagnosis of Personality Disorder based on disturbances in functioning and interpersonal relationships that are entirely a consequence of the symptoms of

Schizotypal Disorder. However, if additional personality features are present that are judged to produce significant problems in interpersonal functioning, an additional diagnosis of Personality Disorder may be appropriate.

6A23 Acute and Transient Psychotic Disorder

Essential (Required) Features:

- Acute onset of psychotic symptoms, which can include delusions, hallucinations, disorganized thinking, or experiences of influence, passivity or control, that emerge without a prodrome, progressing from a non-psychotic state to a clearly psychotic state within 2 weeks. Psychomotor disturbances may also be present, including catatonia.
- Symptoms change rapidly, both in nature and intensity. Such changes may occur from day to day, or even within a single day.
- Absence of negative symptoms (i.e., affective flattening, alogia or paucity of speech, avolition, asociality, anhedonia) during the psychotic episode.
- The duration of the symptoms does not exceed 3 months, and most commonly lasts from a few days to 1 month.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g., a brain tumour), are not due to the effects of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal effects (e.g., from alcohol), and are not better accounted for by Schizophrenia or another Primary Psychotic Disorder..

Course qualifiers for Acute and Transient Psychotic Disorder:

The following qualifiers should be applied to identify the course of Acute and Transient Psychotic Disorder, including whether the individual currently meets the diagnostic requirements for the disorder or is in partial or full remission. If there have been no previous episodes of Acute and Transient Psychotic Disorder, the corresponding single episode qualifier should be applied. If there have been multiple such episodes, the corresponding multiple episodes qualifiers should be applied.

6A23.0 Acute and Transient Psychotic Disorder, first episode

- The first episode qualifier should be applied when the current or most recent episode is the first manifestation of Acute and Transient Psychotic Disorder meeting all diagnostic requirements of the disorder.

6A23.00 Acute and Transient Psychotic Disorder, first episode, currently symptomatic

- All diagnostic requirements for Acute and Transient Psychotic Disorder in terms of symptoms and duration are currently met, or have been met within the past 1 month.
- There have been no previous episodes of Acute and Transient Psychotic Disorder.

6A23.01 Acute and Transient Psychotic Disorder, first episode, in partial remission

- The full diagnostic requirements for Acute and Transient Psychotic Disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been no previous episodes of Acute and Transient Psychotic Disorder.

6A23.02 Acute and Transient Psychotic Disorder, first episode, in full remission

- The full diagnostic requirements for Acute and Transient Psychotic Disorder have not been met within the past month, and no clinically significant symptoms remain.
- There have been no previous episodes of Acute and Transient Psychotic Disorder.

6A23.1 Acute and Transient Psychotic Disorder, multiple episodes

The multiple episodes qualifier should be applied when there has been a minimum of two episodes meeting all diagnostic requirements of Acute and Transient Psychotic Disorder in terms of symptoms and duration, with a period of full remission between episodes lasting at least 3 months.

6A23.10 Acute and Transient Psychotic Disorder, multiple episodes, currently symptomatic

- All diagnostic requirements for Acute and Transient Psychotic Disorder in terms of symptoms and duration are currently met, or have been met within the past 1 month.
- There has been a minimum of two episodes, with a period of full remission between episodes lasting at least 3 months.

6A23.11 Acute and Transient Psychotic Disorder, multiple episodes, in partial remission

- The full diagnostic requirements for Acute and Transient Psychotic Disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There has been a minimum of two episodes, with a period full remission between episodes lasting at least 3 months.

6A23.12 Acute and Transient Psychotic Disorder, multiple episodes, in full remission

- The full diagnostic requirements for Acute and Transient Psychotic Disorder have not been met within the past month, and no clinically significant symptoms remain.
- There has been a minimum of two episodes, with a period of full remission between episodes lasting at least 3 months.

Additional Clinical Features:

- The onset of the disorder is usually associated with a rapid deterioration in social and occupational functioning. Following remission, the person is generally able to regain the premorbid level of functioning.
- There are often other symptoms such as fluctuating disturbances of mood and affect, transient states of perplexity or confusion, or impairment of attention and concentration.
- An episode of acute stress preceding the onset of Acute and Transient Psychotic Disorder is commonly reported, but this is not a diagnostic requirement.
- If the symptoms last for more than 3 months, a different diagnosis should be considered, depending on the specific symptoms (e.g., Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Other Primary Psychotic Disorder).

Boundary with Normality (Threshold):

- Isolated unusual subjective experiences, such as experiences resembling hallucinations and delusions, are reported in the general population. However, in Acute and Transient Psychotic Disorder, the symptoms rapidly progress to full psychosis, they are usually polymorphic, fluctuating in quality and intensity (e.g., having features come and go in relatively rapid succession, or having the nature of a feature change over time, such as the focus or nature of a delusional belief), and usually fully remit within several weeks.

Course Features:

- Symptoms are brief in nature lasting anywhere from a few days but not exceeding 3 months.
- Some individuals diagnosed with Acute and Transient Psychotic Disorder will go on to meet diagnostic requirements for another mental disorder, such as Schizophrenia, another Primary Psychotic Disorder, or a Mood Disorder.
- In general, favourable outcomes are associated with acute onset, short duration, good premorbid functioning, and female gender.

Developmental Presentations:

- Onset of Acute and Transient Psychotic Disorders typically occurs between early and middle adulthood. However, the disorder may occur during adolescence or later in the lifespan often following an episode of acute stress.

Culture-Related Features:

- Migrant populations may be more likely to report these experiences. This may be due to higher prevalence as a result of migration-related stress, misattribution of psychosis by clinicians unfamiliar with cultural expressions of distress, or a combination of the two.
- In some cultures, distress due to social and other environmental circumstances may be expressed in ways that can be misinterpreted as psychotic symptoms (e.g., overvalued ideas and pseudo-hallucinations) but that instead are normative to the person's subgroup.

Gender-Related Features:

- Acute and Transient Psychotic Disorder is more common in females.
- Male gender and younger age of Acute and Transient Psychotic Disorder onset appear to be associated with greater risk of subsequent development of Schizophrenia.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Schizophrenia and Schizoaffective Disorder:*** The psychotic symptoms in Schizophrenia and in Schizoaffective Disorder last for at least 1 month in their full, florid form and tend to be more stable or fixed (e.g., having the same delusion for a period of months). In contrast, the symptoms in Acute and Transient Psychotic Disorder tend to fluctuate rapidly in intensity and type across time, such that the content and focus of delusions or hallucinations often shift, even on a daily basis. Negative symptoms may be present in Schizophrenia and Schizoaffective Disorder, but do not occur in Acute and Transient Psychotic Disorder. The duration of Acute and Transient Psychotic Disorder does not exceed 3 months, and most often lasts from a few days to 1 month, as compared to a much longer typical course for Schizophrenia or Schizoaffective Disorder. Finally, in contrast to Schizophrenia where the onset is often preceded by a history of poor premorbid adjustment, in Acute and Transient Psychotic Disorder the person's symptoms progress rapidly without a prodromal period. In cases that meet both the diagnostic requirements for Acute and Transient Psychotic Disorder (i.e., fluctuating symptoms, acute onset, duration less than 3 months) and Schizophrenia (e.g., delusions and hallucinations for more than 1 month) in the absence of a previous history of Schizophrenia, a diagnosis of Acute and Transient Psychotic Disorder and not Schizophrenia should be assigned.
- ***Boundary with Mood Disorders with psychotic symptoms:*** Depressive and Bipolar Disorders are characterized by a predominant disturbance in mood that persists for at least several days and often much longer. Although mood symptoms may occur in Acute and Transient Psychotic Disorder, they are transient and do not meet the required duration or associated symptoms to qualify for a Depressive, Manic, or Mixed Episode.
- ***Boundary with Acute Stress Reaction and Dissociative Disorders:*** Like Acute and Transient Psychotic Disorder, Acute Stress Reaction and some Dissociative Disorders have an acute onset, often in response to a stressful life experience, and resolve in days to weeks. In contrast, by definition, Acute and Transient Psychotic Disorder includes psychotic symptoms like hallucinations or delusions that do not occur in Disorders Specifically Associated with Stress or in Dissociative Disorders.
- ***Boundary with Delirium:*** In Delirium, the individual has a fluctuating clouding of consciousness (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (i.e., reduced orientation to the environment). In contrast, in Acute and

Transient Psychotic Disorder, the person maintains a regular level of alertness and relatively clear sense of consciousness, despite transient states of perplexity, confusion, and impairment of attention or concentration.

6A24 Delusional Disorder

Essential (Required) Features:

- Presence of a delusion or set of related delusions, typically persisting for at least 3 months and often much longer, in the absence of a Depressive, Manic or Mixed Episode.
- The delusions are variable in content across individuals, while showing remarkable stability within individuals, although they may evolve over time. Common forms of delusions include persecutory, somatic (e.g., a belief that organs are rotting or malfunctioning despite normal medical examination), grandiose (e.g., a belief that one has discovered an elixir that gives eternal life), jealous (e.g., the unjustified belief that one's spouse is unfaithful) and erotomania (i.e., the belief that another person, usually a famous or high-status stranger, is in love with the person experiencing the delusion).
- Absence of clear and persistent hallucinations, severely disorganized thinking (formal thought disorder), experiences of influence, passivity, or control or negative symptoms characteristic of Schizophrenia. However, in some cases, specific hallucinations typically related to the content of the delusions may be present (e.g., tactile hallucinations in delusions of being infected by parasites or insects).
- Apart from the actions and attitudes directly related to the delusional system, affect, speech, and behaviour are typically unaffected.
- The symptoms are not a manifestation of another medical condition (e.g., a brain tumour), are not due to the effects of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal effects (e.g., from alcohol), and are not better explained by another mental disorder (e.g., another Primary Psychotic Disorder, a Mood Disorder, an Obsessive-Compulsive or Related Disorder, an Eating Disorder).

Course qualifiers for Delusional Disorder:

The following qualifiers should be applied to identify whether the individual currently meets the diagnostic requirements of Delusional Disorder or is in partial or full remission.

6A24.0 Delusional Disorder, currently symptomatic

- All diagnostic requirements for Delusional Disorder in terms of symptoms and duration are currently met, or have been met within the past 1 month.

6A24.1 Delusional Disorder, in partial remission

- The full diagnostic requirements for Delusional Disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment

6A24.2 Delusional Disorder, in full remission

- The full diagnostic requirements for Delusional Disorder have not been met within the past month, and no clinically significant symptoms remain.

Additional Clinical Features:

- Delusions may be accompanied by actions directly related to the content of the delusions, for example, stalking the loved person in the context of erotomania or filing lawsuits against those believed to be persecuting the person.
- Delusional Disorder typically has a later onset and greater stability of symptoms than other psychotic disorders with delusional symptoms.
- Rarely, Delusional Disorder may occur at the same time (or closely associated in time) in two persons who have a strong emotional or situational link. This condition is often referred to as shared or induced Delusional Disorder or 'folie-à-deux'. In such cases, one person typically adopts the delusional belief of the other person, and the delusions may remit in the less dominant person when the two individuals are separated.

Boundary with Normality (Threshold):

- A continuum of delusional beliefs, attenuated delusional beliefs, overvalued ideas, and unusual or eccentric beliefs has been observed in the general population. Such beliefs may be more common among people under conditions of adversity. People with Delusional Disorder may display greater psychological distress, greater preoccupation, and higher degree of conviction compared to people in the general population with beliefs that are similar in nature to beliefs that could be characterized as delusional.

Course Features:

- Delusional Disorder typically has a later onset and greater stability of symptoms than other psychotic disorders with delusional symptoms.
- Some individuals with Delusional Disorder will develop Schizophrenia.
- Individuals are more likely to have a premorbid Personality Disorder prior to the onset of Delusional Disorder.
- Levels of functioning are typically better among individuals with Delusional Disorder as compared to those with a diagnosis of Schizophrenia or Other Primary Psychotic disorder.
- Individuals with Delusional Disorder are less likely to require hospitalization in comparison to individuals with other Schizophrenia or Schizoaffective Disorder.

Developmental Presentations:

- Delusional disorder is more prevalent among older individuals.
- Individuals who experience Delusional Disorder in early adulthood are more likely to have a history of hallucinations and severe psychopathology during adolescence.

Cultural Presentation:

- Cultural factors may influence the presentation and diagnosis of Delusional Disorder. For example, spirit possession or witchcraft beliefs may be culturally normative in some but not other cultures.
- Individuals may present with a combination of delusions and overvalued ideas, both drawing on similar cultural idioms and beliefs.
- Diverse populations that experience persecution (e.g., torture, political violence, discrimination due to minority status) may report fears that may be misjudged as paranoid delusions; these may represent instead appropriate fears of recurrence of being persecuted or symptoms of co-occurring Post-Traumatic Stress Disorder. Accurate diagnosis relies on obtaining historical information and considering the cultural context to discern the veracity of persecutory beliefs.

Gender-Related Features:

- There are no prominent gender differences in Delusional Disorder. However, men appear to have a younger age of onset and are more likely to have delusions of jealousy.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Schizophrenia:*** Both Schizophrenia and Delusional Disorder may be characterized by persistent delusions. If other features are present that meet the diagnostic requirements for Schizophrenia (i.e., persistent hallucinations, disorganized thinking, negative symptoms, disorganized or abnormal psychomotor behaviour, or experiences of influence, passivity, or control), a diagnosis of Schizophrenia may be made instead of a diagnosis of Delusional Disorder. However, hallucinations that are consistent with the content of the delusions and do not occur persistently (i.e., with regular frequency for 1 month or longer) are consistent with a diagnosis of Delusional Disorder rather than Schizophrenia. Delusional Disorder is generally characterized by relatively preserved personality and less deterioration and impairment in social and occupational functioning in comparison with Schizophrenia, and individuals with Delusional Disorder tend to present for the first time at a later age. Individuals with symptom presentations consistent with Delusional Disorder (e.g., delusions and related, circumscribed hallucinations) but who have not met the minimum duration requirement of 3 months should not be assigned a diagnosis of Schizophrenia even though the combination of persistent delusions and related hallucinations technically meets diagnostic requirements for Schizophrenia. Instead a diagnosis of Other Primary Psychotic Disorder is more appropriate in such cases.
- ***Boundary with Mood Disorders with psychotic symptoms:*** In Depressive Disorders with psychotic symptoms and Bipolar Disorders with psychotic symptoms, delusions may present during the course of the Mood Episodes. Although mood symptoms, especially depressed mood, can occur in Delusional Disorder, the diagnosis of Delusional Disorder requires that there are times when the person experiences the delusions in the absence of any mood disturbance.
- ***Boundary with Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, Hypochondriasis (Health Anxiety Disorder), Olfactory Reference Disorder, and Anorexia Nervosa:*** A number of mental disorders (i.e., Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, Hypochondriasis, Olfactory Reference Disorder, Anorexia

Nervosa) may involve a recurrent preoccupation with a belief that is demonstrably untrue or that is not shared by others (e.g., that ritualistically washing one's hands prevents harm to loved ones, that a body part is defective, that one has a serious medical illness, that one emits a foul smell, that one is overweight) that may at times appear to be delusional in intensity, in the context of the other clinical features of that disorder. An additional diagnosis of Delusional Disorder should not be given if the belief occurs entirely in the context of symptomatic episodes of one of these other disorders and is fully consistent with its other clinical features.

- ***Boundary with Dementia:*** Delusions, especially persecutory delusions, may occur as a symptom of Dementia, particularly among older adults. Such delusions are differentiated from Delusional Disorder in that they have their onset during the Dementia and are, by definition, due to another medical condition or prolonged substance use. In contrast, the delusions in Delusional Disorder must have had their onset prior to the onset of Dementia. In cases where a Dementia has developed in someone with an established diagnosis of Delusional Disorder, both diagnoses may be assigned.
- ***Boundary with Delirium:*** Delusions may also be a prominent feature of Delirium. In Delirium, however, the individual also has a fluctuating clouding of consciousness (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (i.e., reduced orientation to the environment). In contrast, in Delusional Disorder, there is no disturbance of attention or consciousness.

6A2Y Other Specified Primary Psychotic Disorder

Essential (Required) Features:

- The presentation is characterized by psychotic symptoms that share primary clinical features with disorders in the Schizophrenia or Other Primary Psychotic Disorders grouping (e.g., delusions, hallucinations, formal thought disorder, grossly disorganized or catatonic behaviour).
- The symptoms do not fulfil the diagnostic requirements (e.g., in severity, frequency, or duration) for any other disorder in the Schizophrenia or Other Primary Psychotic Disorders grouping.
- The symptoms are not better accounted for by another Mental, Behavioural or Neurodevelopmental Disorder (e.g., a Mood Disorder, a Disorder Specifically Associated with Stress, a Dissociative Disorder).
- The symptoms or behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g., a brain tumour) and are not due to the effects of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal effects (e.g., from alcohol).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Qualifier Scales for Symptomatic Manifestations of Primary Psychotic Disorders

ICD-11 includes the option of providing a specification of the level of severity for six symptom domains for the disorders included in Schizophrenia or Other Primary Psychotic Disorders. These domains are:

- Positive Symptoms
- Negative Symptoms
- Depressive Mood Symptoms
- Manic Mood Symptoms
- Psychomotor Symptoms
- Cognitive Symptoms

The contribution of each of these symptom domains can be recorded in the form of qualifiers, which can be rated as mild, moderate, or severe, using the guidelines provided in the table below. The ratings should be made based on the severity of the symptoms corresponding to that domain during the past week.

Each domain that contributes significantly to the individual clinical presentation should be rated. As many symptom qualifiers should be applied as necessary to accurately describe the current clinical presentation. A symptom domain can also be recorded with unspecified severity, for example if symptoms corresponding to a particular domain are present but insufficient information is available in order to rate their severity.

In cases where multiple symptoms fall within a particular domain, the rating should reflect the *most* severe symptom within that domain. For example, hallucinations and delusions are both part of the Positive Symptoms domain. A person may experience hallucinations that result in minimal distress (indicative of Mild Positive Symptoms) and delusions that affect the person's behaviour but not to the point of impairing their functioning (indicative of Moderate Positive Symptoms). In that case, the person's positive symptoms should be rated as Moderate. Note that individuals with Primary Psychotic Disorders typically do not present with all of the symptoms that are part of a given qualifier domain. For example, in the Positive Symptoms domain, a person may present with only hallucinations, only delusions, both, or neither. The descriptions corresponding to each rating in the table below are intended to convey examples of symptom presentations that would justify a rating at a particular level of severity; they are not intended to be used as required criteria.

Note that the Mild, Moderate, and Severe ratings for the Depressive Mood Symptoms qualifier are not equivalent to the corresponding diagnostic requirements for a Mild, Moderate, or Severe Depressive Episode. In other words, a rating of mild for Depressive Mood Symptoms in the psychotic disorder qualifiers does not indicate that the individual meets the requirements for a Mild Depressive Episode. The same is true of the Manic Mood Symptoms qualifier. The rating of Depressive and Manic Mood Symptoms in these qualifiers indicates the severity of depressed, elevated, or irritable *mood*, and does not include other symptoms (e.g., disrupted sleep, anhedonia, appetite change) that are part of the diagnostic guidelines for Mood Episodes.

Symptom qualifier ratings are intended to characterize the current clinical presentation among individuals diagnosed with Schizophrenia or Other Primary Psychotic Disorders, and should not be used in individuals without such a diagnosis. Symptoms attributable to the direct pathophysiological consequences of a comorbid medical condition or injury not classified under Mental, Behavioural or Neurodevelopmental Disorders (e.g., a brain tumour or traumatic brain injury), or to the direct physiological effects of substances or medications, including withdrawal effects, should not be included in the qualifier ratings. However, in individuals with Schizophrenia or Other Primary Psychotic Disorders, the specific aetiology of symptoms is often unclear (e.g., whether a mood symptom is due to the psychotic disorder or a result of substance use). In these cases, the relevant symptom should be considered in making the qualifier rating until it becomes clear that the pathogenesis of the symptom is unrelated to the Primary Psychotic Disorder.

General Guidelines for Severity Ratings

Severity	Anchor points
Present and mild	Symptoms in the domain have been present during the past week, but these are minimal in number or do not have a substantial degree of impact. Everyday functioning is not affected by these symptoms, or is affected only minimally. No significant negative social or personal consequences have occurred as a consequence of the symptoms. The symptoms may be intermittent and show fluctuations in severity, and there may be periods during which the symptoms are absent. Compared to other individuals with similar symptoms, the severity of symptoms in the domain is in the mildest third.
Present and moderate	A greater number of symptoms in the domain have been present during the past week or a smaller number of symptoms that have a substantial degree of impact. Everyday functioning may be moderately affected by the symptoms. There are negative social or personal consequences of the symptoms, but these are not severe. Most of the symptoms are present the majority of the time. Compared to other individuals with similar symptoms, the severity of symptoms in the domain is in the middle third.
Present and severe	Many symptoms in the domain have been present during the past week, or a smaller number that have a severe or pervasive degree of impact (i.e., they are intense and frequent or constant). Everyday functioning is persistently impaired due to the symptoms. There are serious negative social or personal consequences. Compared to other individuals with similar symptoms, the severity of symptoms in the domain is in the most severe third.
Unspecified	For example, unable to make a current severity rating based on the available information.

<table>
<tr><td colspan="2">Positive Symptoms

This qualifier may be used together with a diagnosis from the grouping of Schizophrenia or Other Primary Psychotic Disorders to indicate the degree to which positive psychotic symptoms are a prominent part of the current clinical presentation. Positive symptoms include delusions, hallucinations (most commonly verbal auditory hallucinations), disorganized thinking (formal thought disorder such as loose associations, thought derailment, or incoherence), disorganized behaviour (behaviour that appears bizarre, purposeless and not goal-directed) and experiences of passivity and control (the experience that one's feelings, impulses, or thoughts are under the control of an external force). Abnormal psychomotor behaviour (e.g., catatonic restlessness or agitation, waxy flexibility, negativism) is not included in this domain but instead would be rated in the Psychomotor Symptoms domain below.

The rating should be made based on the severity of positive symptoms during the past week.</td></tr>
<tr><td>Mild
6A25.0&XS5W</td><td>Example symptoms (not all are required):
Delusions: The person believes the delusion (lack of reality testing), but does not feel pressure to act upon it and the delusion leads to minimal distress.
Hallucinations: Hallucinations are recurrent but relatively infrequent, and the person expresses only minimal distress regarding their content.
Experiences of Passivity and Control: Some distortions of self-experience, such as feeling that one’s thoughts are not one’s own, but these are relatively infrequent and there is only minimal associated distress.
Disorganized Thinking: Some circumstantial or tangential thought process, but for the most part the individual is able to convey the point of the intended communication.
Disorganized Behaviour: Infrequent episodes of purposeless behaviour that is not goal-directed and causes only minimal impairment in functioning.</td></tr>
<tr><td>Moderate
6A25.0&XS0T</td><td>Example symptoms (not all are required):
Delusions: The person’s behaviour is clearly affected by the delusional beliefs but the person’s behavioural response does not significantly impair functioning (e.g., a person with persecutory delusions is watchful of his surroundings but continues to venture outside).
Hallucinations: Hallucinations are relatively frequent and may be distressing at times but are tolerated at other times, and do not persistently preoccupy the person. The content of</td></tr>
</table>

	hallucinations may prompt action, but the person only inconsistently or occasionally responds and these actions do not put the person or others at risk of harm. **Experiences of Passivity and Control:** Distortions of self-experience are relatively frequent and lead to some behaviours to ward against alteration of thoughts (e.g., superstitious rituals), or noticeable distress. **Disorganized Thinking:** Evidence of frequent circumstantial or tangential thought process that impairs the individual's ability to convey the point of the communication. **Disorganized Behaviour:** Frequent episodes of purposeless behaviour that is not goal-directed and that causes some impairment in functioning.
Severe 6A25.0&XS25	*Example symptoms (not all are required):* **Delusions:** The person is preoccupied with delusional beliefs that dictate many of the person's actions and significantly impair functioning (e.g., a person with persecutory delusions refuses to eat most food because of a conviction that food has been poisoned). **Hallucinations:** The person is markedly distressed or preoccupied by frequent hallucinations or there are recurrent hallucinations that prompt potentially harmful behaviour to which the person feels compelled to respond. **Experiences of Passivity and Control:** Distortions of self-experience are markedly distressing, and significantly impact the individual's behaviour (e.g., wearing a hat made of aluminium foil to prevent thought broadcasting). **Disorganized Thinking:** Loose associations in thought processes that are so severe that speech is mostly incoherent. **Disorganized Behaviour:** Purposeless behaviour that is not goal-directed dominates the individual's behavioural repertoire and causes severe impairment in functioning.
Unspecified 6A25.0	For example, unable to make a rating based on available information.
Negative Symptoms This qualifier may be used together with a diagnosis from the grouping of Schizophrenia or Other Primary Psychotic Disorders to indicate the degree to which negative psychotic	

<table>
<tr><td colspan="2">symptoms are a prominent part of the current clinical presentation. Negative symptoms include constricted, blunted, or flat affect; alogia or paucity of speech; avolition (general lack of drive, or lack of motivation to pursue meaningful goals); asociality (reduced or absent engagement with others and interest in social interaction) and anhedonia (inability to experience pleasure from normally pleasurable activities). To be considered negative psychotic symptoms, relevant symptoms should not be entirely attributable to depression or to an under-stimulating environment, be a direct consequence of a positive symptom (e.g., persecutory delusions causing a person to become socially isolated due to fear of harm), or be attributable to the direct physiological effects of substances or medications, including withdrawal effects. Catatonia, including catatonic mutism, should be considered as part of the rating of the Psychomotor Symptoms qualifier, rather than here.

The rating should be made based on the severity of negative symptoms during the past week.</td></tr>
<tr><td>Mild
6A25.1&XS5W</td><td>Example symptoms (not all are required):
Blunted emotional experience or expression, with subtle but detectable affective changes. Limited initiation of speech, but is responsive to questions. Little interest in external events, but exhibits sufficient motivation to engage in basic activities of daily living or to complete a task when prompted.</td></tr>
<tr><td>Moderate
6A25.1&XS0T</td><td>Example symptoms (not all are required):
Flat emotional expression. Minimal initiation of speech for purposes other than indicating immediate needs and desires, but is responsive to questions with terse phrases. Lack of volition leads to neglect of hygiene or required activities, but will complete them with significant prompting.</td></tr>
<tr><td>Severe
6A25.1&XS25</td><td>Example symptoms (not all are required):
Person reports feeling empty or robotic most of the time. Generally does not initiate speech, even to indicate immediate needs and desires. Person is not capable of initiating behaviour even with significant prompting, which may lead to serious neglect of self-care to the extent that it puts the person at risk of harm (e.g., infrequently taking life-sustaining medication).</td></tr>
<tr><td>Unspecified
6A25.1</td><td>For example, unable to make a rating based on available information.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Depressive Mood Symptoms

This qualifier may be used together with a diagnosis from the grouping of Schizophrenia or Other Primary Psychotic Disorders to indicate the degree to which depressive mood symptoms are a prominent part of the current clinical presentation. The qualifier refers only to depressive mood symptoms, as reported by the individual (feeling down, sad) or as</td></tr>
</table>

observed by the clinician (e.g., tearful, defeated appearance). The severity of associated non-mood symptoms of a Depressive Episode (e.g., anhedonia or other negative symptoms, changes in sleep or appetite) should not be considered in making a rating for this qualifier. In this regard, the Depressive Mood Symptoms qualifier is different from the severity rating applied to a Depressive Episode (see page XX). If suicidal ideation is present, a rating of moderate or severe depressive mood symptoms should automatically be applied (see below). This qualifier may be used regardless of whether the depressive symptoms meet the diagnostic requirements for a Depressive Episode.

The rating should be made based on the severity of depressive mood symptoms during the past week.

Mild 6A25.2&XS5W	The person expresses significant depressed mood, but there are intermittent periods of relief. The depressive symptoms have some, but not considerable, impact on personal, social, or occupational functioning.
Moderate 6A25.2&XS0T	The depressed mood is present continually, although its intensity may vary. Suicidal ideation may accompany the depressed mood when it is more intense. The depressive symptoms cause considerable difficulty with personal, social, or occupational functioning.
Severe 6A25.2&XS25	The intensity of the depressed mood is overwhelming to the person. This level of severity may be indicated by intense suicidal ideation or suicide attempts. The depressive symptoms seriously affect personal, social, and occupational functioning to such an extent that the person is unable to function, except to a very limited degree.
Unspecified 6A25.2	For example, unable to make a rating based on available information.

Manic Mood Symptoms

This qualifier may be used together with a diagnosis from the grouping of Schizophrenia or Other Primary Psychotic Disorders to indicate the extent to which manic mood symptoms are a prominent part of the clinical presentation. The qualifier includes elevated, euphoric, irritable, or expansive mood states, including rapid changes among different mood states (i.e., mood lability). It also includes increased subjective experience of energy, which may be accompanied by increased goal-directed activity. The severity of associated non-mood symptoms of a Manic or Hypomanic Episode (e.g., decreased need for sleep, distractibility) should not be considered in making a rating for this qualifier. Increased non-goal-directed psychomotor activity should be considered as part of the rating of the Psychomotor Symptoms qualifier rather than here. This qualifier may be used regardless of whether the manic symptoms meet the diagnostic requirements for a Manic Episode.

The rating should be made based on the severity of manic mood symptoms during the past week.	
Mild 6A25.3&XS5W	Hypomanic elevation of mood or increased irritability. The hypomanic symptoms do not cause marked impairment in personal, social, or occupational functioning.
Moderate 6A25.3&XS0T	Marked elevation of mood, irritability, or subjective energy level. The manic symptoms cause considerable difficulty with personal, social, or occupational functioning.
Severe 6A25.3&XS25	Extreme elevation of mood or irritability that results in hazardous, dangerous, or markedly inappropriate behaviour to a degree that intensive supervision is required.
Unspecified 6A25.3	For example, unable to make a rating based on available information.
Psychomotor Symptoms This qualifier may be used together with a diagnosis from the grouping of Schizophrenia or Other Primary Psychotic Disorders to indicate the degree to which psychomotor symptoms are a prominent part of the clinical presentation. Psychomotor symptoms include psychomotor agitation or increased motor activity, usually manifested by purposeless behaviours such as fidgeting, shifting, fiddling, inability to sit or stand still, wringing of the hands, stereotypy, and grimacing. Psychomotor symptoms also include psychomotor retardation (a visible generalized slowing of movements and speech), as well as catatonic symptoms such as extreme restlessness with purposeless motor activity to the point of exhaustion, posturing, waxy flexibility, negativism, mutism, or stupor. To be considered psychomotor symptoms for the purpose of this qualifier rating, symptoms should not be attributable a Neurodevelopmental Disorder or Disease of the Nervous System or to the direct physiological effects of substances or medications, including withdrawal effects. If the full syndrome of Catatonia is present, the diagnosis of Catatonia Associated with Another Mental Disorder (p.) should also be assigned. The rating should be made based on the severity of psychomotor symptoms during the past week.	
Mild 6A25.4&XS5W	The majority of the time the person exhibits a normal level of activity, but there are occasional periods of psychomotor excitation or slowing. Psychomotor symptoms do not significantly interfere with important personal, social, or occupational functioning.
Moderate 6A25.4&XS0T	Frequent periods of marked psychomotor agitation or retardation, but psychomotor symptoms are not continuous. Psychomotor symptoms significantly

	interfere with important personal, social, or occupational functioning.
Severe 6A25.4&XS25	Severe and nearly continuous psychomotor agitation or slowing, including full catatonia (e.g., stupor, waxy flexibility, catalepsy, rigidity). The agitation or slowing is sufficiently severe to be potentially harmful to the person or others (e.g., agitation to the point of severe physical exhaustion, stupor that prevents the person from feeding himself).
Unspecified 6A25.4	For example, unable to make a rating based on available information.
Cognitive Symptoms This qualifier may be used together with a diagnosis from the grouping of Schizophrenia or Other Primary Psychotic Disorders to indicate the degree to which cognitive impairment is a prominent aspect of the clinical presentation. The rating should be made based on the severity of cognitive symptoms during the past week. Deficits may appear in any of the following cognitive domains: *speed of processing, attention/concentration, orientation, judgment, abstraction, verbal or visual learning, or working memory.* The cognitive impairment is not attributable to a Neurodevelopmental Disorder or to Delirium or another Neurocognitive Disorder or to the direct effects of a substance or medication on the central nervous system, including withdrawal effects. When available, the severity rating for this domain should be based on the results of locally validated, standardized neuropsychological assessments, but such measures are not available in all settings and are not required to provide a rating.	
Mild 6A25.5&XS5W	Person has minor difficulties in cognition (e.g., difficulty with recall during the interview, concentration may drift, shows some disorientation to time but not person or place). Everyday functioning is largely unimpaired by the difficulties.
Moderate 6A25.5&XS0T	Person shows clear difficulties in cognition (e.g., recall for some autobiographical information is impaired or inconsistent, cannot perform some basic operations that are expected of the person's educational attainment and level of intellectual functioning such as simple calculation tasks, orientation disrupted for time and place but intact for person, difficulty learning or retaining new information). Everyday functioning is impaired as a result but only some external assistance is necessary.
Severe 6A25.5&XS25	Person shows pronounced difficulties in cognition (e.g., severe deficits in verbal memory or other cognitive tasks relative to educational attainment

	and level of intellectual functioning, substantial difficulty with concentration and attention to what the rater asks during the interview, difficulty formulating plans to accomplish a specific objective, unable to consider alternative solutions to problems, orientation is grossly disturbed). The problems severely interfere with everyday functioning leading to the necessity of considerable external assistance.
Unspecified 6A25.5	For example, unable to make a rating based on available information.