ICD-11: Schizophrenia or Other Primary Psychotic Disorders

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Disclosure

• Member of the APA DSM-5 working group on psychotic disorders
• Chair of the WHO ICD-11 working group on psychotic disorders
• Member of the WHO FSCG for MBND, the WHO-FIC MSAC and the WHO Advisory Group on Training and Implementation for ICD-11 MBND
• DGPPN Commissioner for ICD-11 MBND
• Member of the German KKG / DIMDI / AWMF ICD-11 working group
• Member of the Lundbeck International Neuroscience Foundation (LINF)
The Concept of Psychotic Disorders

- The term *Psychosis* has originally been introduced in 1845 (Ernst Freiherr v. Feuchtersleben*) and was used later on for severe mental disorders.
- Psychosis nowadays denotes a clinical syndrome, not a nosological entity.
- A psychotic syndrome is usually defined as being composed of hallucinations, delusions and disordered thinking/behaviour.
- Divide primary and secondary psychotic disorders.
- Not (yet) defined by laboratory tests, genetic or neuroimaging techniques.

* 1806-1848, Vienna; MD and poet; Diätetik d. Seele (1838), Lehrbuch d. ärztl. Seelenkunde (1845)
ORIGINS OF THE CONCEPT OF SCHIZOPHRENIA

‘Dementia praecox’ (1893)
- Defining (mental) disease entities based on an “overall clinical picture” of symptoms, course and outcome (with a postulated common underlying etiology)
- Dementia praecox (vs. manic-depressive insanity):
  - (Early) Onset in adolescence or early adulthood
  - Chronic and deteriorating course
  - Poor outcome with permanent and pervasive impairment in mental functions

‘Group of Schizophrenias’ (1911)
[from Greek schizein (splitting) and phren (soul, spirit, mind)]
- A group of disorders sharing a set of clinical features (with different etiology)
- Fundamental symptoms (‘Grundsymptome’):
  loss of associations, inappropriate affect, ambivalence avolition, and autism
- Accessory symptoms: hallucinations, delusions ...
- Primary and secondary symptoms
- Variability in course and outcome

‘1st and 2nd rank symptoms’ (1938)
- 1st: hearing commenting or conversing voices, thoughts being inserted or withdrawn, delusions of being controlled ...
- 2nd: other auditory hallucinations, visual hallucinations, delusional ideas ...

Emil Kraepelin  *1856 † 1926
Eugen Bleuler  *1857 † 1939
Kurt Schneider  *1887 † 1967
The Evolution of the Schizophrenia Concept

Status Report on ICD-11 Psychotic Disorders


Etc.
<table>
<thead>
<tr>
<th>ICD-11 Schizophrenia or Other Primary Psychotic Disorders</th>
<th>ICD-10 Schizophrenia, Schizotypal and Delusional Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>Schizoaffective Disorder</td>
</tr>
<tr>
<td>Acute and Transient Psychotic Disorder</td>
<td>Acute and Transient Psychotic Disorder:</td>
</tr>
<tr>
<td></td>
<td>1 Acute Polymorphic Psychotic Disorder without Symptoms of Schizophrenia</td>
</tr>
<tr>
<td></td>
<td>2, 3, 4 see below</td>
</tr>
<tr>
<td>Schizotypal Disorder</td>
<td>Schizotypal Disorder</td>
</tr>
<tr>
<td>Delusional Disorder</td>
<td>Persistent Delusional Disorder</td>
</tr>
<tr>
<td></td>
<td>Induced Delusional Disorder</td>
</tr>
<tr>
<td></td>
<td>4 Other Acute Predominantly Delusional Psychotic Disorder</td>
</tr>
<tr>
<td>Other Primary Psychotic Disorder</td>
<td>3 Acute Schizophrenia-like Psychotic Disorder</td>
</tr>
<tr>
<td></td>
<td>2 Acute Polymorphic Psychotic Disorder with Symptoms of Schizophrenia</td>
</tr>
</tbody>
</table>
## ICD-11 Clinical Field Studies on the Diagnostic Reliability of Mental Disorders

N=339 clinicians; N=1,806 patients; 28 routine clinical centers in 13 countries

(Brazil, Canada, China, India, Italy, Japan, Lebanon, Mexico, Nigeria, Russia, South Africa, Spain, Tunisia)

<table>
<thead>
<tr>
<th>ICD-11 EIFS</th>
<th>Kappa (N)</th>
<th>ICD-10 CDDD field trail (1993)</th>
<th>Kappa (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>0.87 (725)</td>
<td>F20 Schizophrenia</td>
<td>0.81 (490)</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>0.66 (189)</td>
<td>F36 Schizoaffective disorder</td>
<td>0.48 (148)</td>
</tr>
<tr>
<td>Acute and transient psychotic disorder</td>
<td>0.45 (40)</td>
<td>F23 Acute/transient psychotic disorders</td>
<td>0.65 (146)</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>0.69 (30)</td>
<td>F22.0 Delusional disorder</td>
<td>0.62 (83)</td>
</tr>
<tr>
<td>Bipolar I disorder</td>
<td>0.84 (351)</td>
<td>F30 Manic episode</td>
<td>0.69 (53)</td>
</tr>
<tr>
<td>Single episode depressive disorder</td>
<td>0.64 (191)</td>
<td>F32 Depressive episode</td>
<td>0.66 (353)</td>
</tr>
<tr>
<td>Recurrent depressive disorder</td>
<td>0.74 (267)</td>
<td>F33 Recurrent depressive disorders</td>
<td>0.69 (302)</td>
</tr>
<tr>
<td>Dysthymic disorder</td>
<td>0.45 (57)</td>
<td>F34.1 Dysthymia</td>
<td>0.56 (101)</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>0.62 (129)</td>
<td>F41.1 Generalized anxiety disorder</td>
<td>0.48 (67)</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>0.57 (59)</td>
<td>F41.0 Panic disorder</td>
<td>0.74 (31)</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>0.62 (46)</td>
<td>F40.0 Agoraphobia</td>
<td>0.51 (22)</td>
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<tr>
<td>Social anxiety disorder</td>
<td>0.88 (38)</td>
<td>F40.1 Social phobias</td>
<td>0.41 (22)</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>0.49 (51)</td>
<td>F43.1 Post-traumatic stress disorder</td>
<td>0.62 (23)</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>0.73 (82)</td>
<td>F43.2 Adjustment disorder</td>
<td>0.54 (107)</td>
</tr>
</tbody>
</table>

**Interpretation of Kappa values** (i.e., inter-rater agreement between two raters; Landis & Koch, 1977):
- slight (0-0.20), fair (0.21-0.40), moderate (0.41-0.60), substantial (0.61-0.80), almost perfect (0.81-1.00)

N = 928 Health Professionals from all WHO-Regions
Data collection via the WHO Global Practice Network
10 case vignettes based on ICD-10 or ICD-11 mental disorders diagnostic guidelines
Assessment of diagnostic accuracy and perceived clinical utility
# INTERNATIONAL ICD-11/10 VIGNETTE-BASED FIELD TRIAL DIAGNOSTIC ACCURACY

<table>
<thead>
<tr>
<th>Vignette</th>
<th>n</th>
<th>ICD-11 % correct</th>
<th>ICD-10 % correct</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>928</td>
<td>71.9</td>
<td>53.2</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>94</td>
<td>74.4</td>
<td>78.4</td>
<td>0.647</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>95</td>
<td>63.5</td>
<td>44.2</td>
<td>0.062</td>
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<tr>
<td>Bipolar Disorder Type II</td>
<td>90</td>
<td>68.4</td>
<td>9.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Recurrent Depressive Disorder</td>
<td>97</td>
<td>81.6</td>
<td>66.7</td>
<td>0.096</td>
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<tr>
<td>Moderate Personality Disorder</td>
<td>89</td>
<td>57.4</td>
<td>73.8</td>
<td>0.108</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>92</td>
<td>34.6</td>
<td>55.0</td>
<td>0.052</td>
</tr>
<tr>
<td>Complex PTSD</td>
<td>95</td>
<td>71.1</td>
<td>32.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Binge Eating Disorder</td>
<td>92</td>
<td>86.5</td>
<td>87.5</td>
<td>0.892</td>
</tr>
<tr>
<td>Bodily Distress Disorder</td>
<td>89</td>
<td>95.5</td>
<td>37.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Compulsive Sexual Behaviour Disorder</td>
<td>95</td>
<td>89.3</td>
<td>48.7</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
# INTERNATIONAL ICD-11/10 VIGNETTE-BASED FIELD TRIAL CLINICAL UTILITY

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Ease of use</th>
<th>Goodness of fit</th>
<th>Clarity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICD-11</td>
<td>ICD-10</td>
<td>( p )</td>
</tr>
<tr>
<td>Overall</td>
<td>3.2 (0.6)</td>
<td>3.0 (0.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3.1 (0.6)</td>
<td>3.0 (0.7)</td>
<td>0.281</td>
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<tr>
<td>Schizoaffective Disorder</td>
<td>3.0 (0.7)</td>
<td>2.6 (0.9)</td>
<td>0.021</td>
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<tr>
<td>Bipolar Disorder Type II</td>
<td>2.9 (0.7)</td>
<td>3.0 (0.8)</td>
<td>0.762</td>
</tr>
<tr>
<td>Recurrent Depressive Disorder</td>
<td>3.4 (0.6)</td>
<td>3.5 (0.7)</td>
<td>0.778</td>
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<tr>
<td>Moderate Personality Disorder</td>
<td>3.0 (0.5)</td>
<td>3.0 (0.7)</td>
<td>0.920</td>
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<tr>
<td>Adjustment Disorder</td>
<td>3.0 (0.5)</td>
<td>2.8 (0.6)</td>
<td>0.121</td>
</tr>
<tr>
<td>Complex PTSD</td>
<td>3.3 (0.7)</td>
<td>3.2 (0.6)</td>
<td>0.425</td>
</tr>
<tr>
<td>Binge Eating Disorder</td>
<td>3.5 (0.6)</td>
<td>3.0 (0.7)</td>
<td>0.001</td>
</tr>
<tr>
<td>Bodily Distress Disorder</td>
<td>3.3 (0.6)</td>
<td>3.1 (0.8)</td>
<td>0.156</td>
</tr>
<tr>
<td>Compulsive Sexual Behaviour Disorder</td>
<td>3.3 (0.7)</td>
<td>2.9 (0.6)</td>
<td>0.005</td>
</tr>
</tbody>
</table>

ICD-10 term ‘nonorganic’ psychotic disorders has been changed to ‘primary’ psychotic disorders to avoid suggesting these disorders are not brain-based

Acute and Transient Psychotic Disorder and Delusional Disorder substantially simplified

Course Qualifiers

Symptom Qualifiers and Severity Ratings
ICD-11 Schizophrenia - What is new?

• **De-emphasis of first-rank symptoms**
  *Due to a lack of clinical evidence that ‘first-rank’ symptoms are specific for schizophrenia*

• **Omission of classical schizophrenia subtypes**
  *Due to a lack of clinical evidence for prospective value and clinical stability*

• **Introduction of cognitive symptoms as symptoms of schizophrenia**
  *Due to compelling evidence that cognitive symptoms are closely related to clinically relevant functional impairments (especially important for rehabilitation services)*

• **Introduction of new course qualifiers** *(for all primary psychotic disorders)*
  *To acknowledge the evidence that there are different types of disease courses and a need to differentiate between first and recurrent episodes emphasizing early diagnosis and treatment*

• **Introduction of symptom qualifiers** *(for all primary psychotic disorders)*
  *To acknowledge the evidence that there is a spectrum of symptoms with time-variable clinical presentations and fuzzy borders to ‘normality’ and other mental disorders (‘dimensional concept’)*
ICD-11 Schizophrenia: *Deemphasis of First-Rank Symptoms*

**Rationale:**

- Limited diagnostic sensitivity, but good specificity.  

- The reliability of bizarre delusions has been found to be poor.  

- FRS common but not helpful for differentiating schizophrenia from other psychoses as they occurred frequently in other types.  

- FRS are also common in other types of psychoses in the early stages of the illness, may aid early detection.  
  Ramperti et al. JNMD 2010; 198: 820-823; Soares-Weiser et al., Cochrane Database Syst Rev 2015;CD010653

> ‘Until the status of FRS is clarified in depth, we suggest that the FRS, as these are currently defined, should be de-emphasized in the next revisions of our diagnostic systems.’  
ICD-11 Schizophrenia: *Replacement of subtypes with symptom qualifiers*

**Rationale:**

- Cluster analytic and other approaches to identify taxonic schizophrenia subtypes consistently fail to identify the DSM-IV subtypes.  
  *Picardi et al., Psychiatry Res. 2012;198, 386–394.*

- A review of 24 publications describing 38 analyses of 28 participant cohorts found no support for classic schizophrenia subtypes.  
  *Linscott et al., Schizophr Bull 2010; 36: 811-829*

- Subtypes continue to be found to exhibit poor diagnostic stability over time, do not cluster in families, and have limited prognostic value.  
  *Tandon et al., Schizophr Res 2009, 110: 1-23*

- Except for the paranoid and undifferentiated subtypes, the other subtypes are rarely utilized in most mental health care settings across the world.  
  *Tandon et al., Schizophrenia Research 2013;150 :3–10*
ICD-11 Schizophrenia: *Cognitive impairment in the clinical description*

**Rationale:**
- Relevant for prognosis and management of schizophrenia
- Helps clinicians and families to anticipate the degree of problems in work, school, social functioning, or rehabilitation
- Helps explain difficulties people with schizophrenia encounter and reduce unrealistic expectations

Neurocognitive impairments and negative symptoms are related to poorer psychosocial outcome in first-episode schizophrenia


Neurocognitive factors predict 52% of the variance in return to work or school in schizophrenia

*Nuechterlein et al., Schizophr Bull 2011; 37 (Suppl. 2):S33-S40*

Cognitive remediation and cognitive behavioral therapy are effective in reducing negative symptoms in schizophrenia

*Klingberg et al., Schizophr Bull 2011; 37 (Suppl. 2):S98-S110*

Cognitive training improves the outcome of vocational rehabilitation therapy in schizophrenia

COURSE QUALIFIERS (PRE-COORDINATED)

**Longitudinal course:**
- First episode - current or most recent episode is first manifestation of disorder
- Multiple episodes - minimum of 2 episodes with 3+ months period of partial or full remission
- Continuous - present for almost all of the course for at least one year

**Cross-sectional symptom status** (i.e., *past month*):
- Currently symptomatic - definitional requirements currently met
- In partial remission - some clinically significant symptoms remain
- In full remission - no symptoms remain
SYMPTOM QUALIFIER RATINGS (POST-COORDINATED)

- Replace subtypes

- Rate each individual with any primary psychotic disorder on all six domains:
  - Positive Symptoms
  - Negative Symptoms
  - Depressive Mood Symptoms
  - Manic Mood Symptoms
  - Psychomotor Symptoms
  - Cognitive Symptoms

Symptom Qualifier Severity Rating Scale

0 = Not Present
1 = Present but mild
2 = Present and moderate
3 = Present and severe
9 = Unable to make a rating based upon available information
QUALIFIER SCALES (GENERIC SEVERITY OPERATIONALIZATIONS) FOR SYMPTOMATIC MANIFESTATIONS OF PRIMARY PSYCHOTIC DISORDERS

The contribution of each of the 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. As many symptom qualifiers should be applied as necessary to accurately describe the current clinical presentation. The ratings should be made based on the severity of the symptoms corresponding to that domain during the past week.

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>ANCHOR POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present and mild</td>
<td>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.</td>
</tr>
<tr>
<td>Present and moderate</td>
<td>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.</td>
</tr>
<tr>
<td>Present and severe</td>
<td>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.</td>
</tr>
<tr>
<td>Unspecified</td>
<td>For example, unable to make a current severity rating based on the available information.</td>
</tr>
</tbody>
</table>
Positive symptoms:

- Hallucinations, delusions, disorganized thinking, disorganized behaviour, experiences of passivity and control
- Catatonia not included here but under Psychomotor Symptoms qualifier
<table>
<thead>
<tr>
<th>Example symptoms (not all are required):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MILD</strong></td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td><strong>Delusions</strong></td>
</tr>
<tr>
<td><strong>Hallucinations</strong></td>
</tr>
<tr>
<td><strong>Experiences of Passivity and Control</strong></td>
</tr>
<tr>
<td><strong>Disorganized Thinking</strong></td>
</tr>
<tr>
<td><strong>Disorganized Behaviour</strong></td>
</tr>
</tbody>
</table>
Negative symptoms:

- Alogia, limited affect, avolition, anhedonia, asociality
- Not attributable to depression, under-stimulating environment, positive symptoms, effects of medications or substance use
Depressive mood symptoms:

- Refers only to depressed mood and related symptoms (e.g., tearfulness); severity of associated non-mood symptoms (e.g., anhedonia, changes in sleep or appetite) is not included in rating, except for suicidal ideation/Attempts, which contribute to ratings of ‘moderate’ and ‘severe’

- Not the same as severity ratings for Depressive Episode
Manic mood symptoms:

- Refers to elevated, irritable or expansive mood plus increase in energy; associated symptoms not included
- Increased psychomotor activity rated under Psychomotor Symptoms qualifier
Psychomotor symptoms:

- Psychomotor agitation, psychomotor retardation, catatonic* symptoms (e.g., posturing, waxy flexibility, mutism, stupor)
- Not attributable to pre-existing neurological condition or to medication side effects

* Catatonia
  6A40 Catatonia associated with another mental disorder
  6A41 Catatonia induced by substances or medications
  6E69 Secondary catatonia syndrome
  6A4Z Catatonia unspecified
## EXAMPLE SYMPTOM QUALIFIER SCALING: PSYCHOMOTOR SYMPTOMS

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>Example symptoms (not all are required):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Severe</strong></td>
<td>Severe and nearly continuous psychomotor agitation or slowing, which may include the full syndrome of Catatonia. The psychomotor symptoms are 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).</td>
</tr>
</tbody>
</table>
Cognitive symptoms:

- Deficits in speed of processing, attention/concentration, orientation, judgment, abstraction, verbal or visual learning, working memory

- Ideally based on locally validated standardized assessments but these are not required
ICD-11 SCHIZOPHRENIA: CLINICAL DIAGNOSTIC GUIDELINES

Characterized by disturbances in multiple mental functions:

a) Persistent delusions
b) Persistent hallucinations
c) Disorganized thinking
d) Experiences of influence, passivity or control
e) Negative symptoms
f) Grossly disorganized behaviour
g) Psychomotor disturbances

At least two of these symptoms must be present most of the time for a period of at least 1 month. **Core symptoms:** At least one of the qualifying symptoms should be from item a) through d). Symptoms or behaviours are *not a manifestation of another medical condition* (e.g., a brain tumour) and are *not due to the effect of a substance or medication, including withdrawal effects* (e.g., alcohol). Symptoms are typically accompanied by impairment in cognitive functioning and (other) psychosocial problems.
COMPLEX CODING WITH COURSE-, SYMPTOM-, AND SEVERITY-QUALIFIERS

Example: SCHIZOPHRENIA, first episode, in partial remission (precoordinated)

https://icd.who.int/browse11
INDIVIDUAL SYMPTOM PROFILES (EXAMPLES)

Patient 1: Schizophrenia, first episode, in partial remission (6A20.01) with
• Mild negative symptoms (6A25.1 & XS5W),
• Moderate depressive symptoms (6A25.2 & XY0T)
• Mild cognitive symptoms (6A25.5 & XS5W)

ICD-10 Code: F20.0
ICD-11 Code: 6A20.01/6A25.1&XS5W/6A25.2&XY0T/6A25.5&XS5W

Patient 2: Schizophrenia, multiple episodes, currently symptomatic (6A20.10) with
• Severe positive symptoms (6A25.0 & XS25),
• Severe manic mood symptoms (6A25.3 & XS25) and
• Moderate cognitive symptoms (6A25.5 & XY0T)

ICD-10 Code: F20.0
ICD-11 Code: 6A20.01/6A25.0&XS25/6A25.3&XS25/6A25.5&XY0T

Markedly different symptom profiles and severity gradings (corresponding to different treatment options) are only evident in ICD-11 (pre- and post-coordination), but not in ICD-10
Overall Coding Consistency of ICD-11 vs ICD-10 in 25 Mental Health Disorders (WHO ICD-FiT Platform)

(N=531 assessments of 120 participants)

Coding Consistency: Utility Assessments

**Time for Code Assignment**
Advantages / less time in secs. for ICD-10 vs. ICD-11, but improvement for ICD-11 by repetition

- **Overall**: ICD-10 31.7, ICD-11 46.3 (p=0.02)
- **Case 1**: ICD-10 22.4, ICD-11 16.6 (p=0.005)
- **Case 2**: ICD-10 43.5, ICD-11 33.9
- **Case 3**: ICD-10 33.9, ICD-11 27.8
- **Case 4**: ICD-10 27.8, ICD-11 22.4
- **Case 5**: ICD-10 9.5, ICD-11 (n.s.)

**Perceived Difficulties (% Yes)**

- **Overall**: ICD-10 22.4, ICD-11 16.6 (p<0.001)
- **Case 1**: ICD-10 22.4, ICD-11 16.6 (p<0.001)
- **Case 2**: ICD-10 43.5, ICD-11 33.9
- **Case 3**: ICD-10 33.9, ICD-11 27.8
- **Case 4**: ICD-10 27.8, ICD-11 22.4
- **Case 5**: ICD-10 9.5, ICD-11 (n.s.)

**Assessed Specificity (%)**

- **Just right**: ICD-10 56.0, ICD-11 76.6 (p<0.001)
- **Not detailed enough**: ICD-10 20.0, ICD-11 41.7
- **Too detailed**: ICD-10 3.5, ICD-11 2.3

**Perceived Ambiguity (% Yes)**

- **Overall**: ICD-10 20.7, ICD-11 34.8 (p<0.001)
- **Case 1**: ICD-10 20.7, ICD-11 34.8 (p<0.001)
- **Case 2**: ICD-10 43.5, ICD-11 33.9
- **Case 3**: ICD-10 33.9, ICD-11 27.8
- **Case 4**: ICD-10 27.8, ICD-11 22.4
- **Case 5**: ICD-10 9.5, ICD-11 (n.s.)

Capacity Building for ICD-11 Coding*

<table>
<thead>
<tr>
<th>Activities</th>
<th>WHO Tooling available</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST: Form a national taskforce for implementation, including all relevant stakeholders and ensure support by highest government levels.</td>
<td></td>
<td>Q 1</td>
<td>Q 2</td>
</tr>
<tr>
<td>Evaluate the impact of training activities for coders, physicians and other personnel on quality indicators</td>
<td>ICD11 FIT</td>
<td>Q 3</td>
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<tr>
<td>Develop a coder profile and certification</td>
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* WHO ICD-11 Implementation or Transition Guide
Schizophrenia: DSM-5 and ICD-11

**DSM-5**

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated).
   At least one of these must be (1), (2), or (3):
   
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech (e.g., frequent derailment or incoherence).
   4. Grossly disorganized or catatonic behavior.
   5. Negative symptoms (i.e., diminished emotional expression or avolition).

**ICD-11**

B. Social/occupational dysfunction

C. Duration (6 months)

D. Schizoaffective and Mood Disorder Exclusion

E. Substance/General Medical Condition Exclusion

F. Relationship to a Pervasive Developmental Disorder

At least two of the following (one of which must be from the list of [a] to [d]) must be present (by patient report or observation by the clinician or other informants) most of the time for a period of 1 month or more:

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 (e.g., the experience that thoughts are not generated by the person, are being placed in one’s mind or withdrawn from one’s mind by others, or that thoughts are being broadcast to others).

e. Negative symptoms, such as affective flattening, aloxia or paucity of speech, avolition, asociality and anhedonia.

f. Grossly disorganized behavior, which may be noted in any form of goal-directed activity (e.g., unpredictable or inappropriate emotional responses, behavior that appears bizarre or purposeless).

g. Psychomotor disturbances, such as cataleptic restlessness or agitation, posturing, waxy flexibility, negativism, mutism, or stupor.

Exclude other health condition/substance or medication use; may be associated with significant distress and/or impaired functioning.
ICD-11 Schizophrenia: *Include ‘Functional Impairment’ as a mandatory criterion?*

**Rationale for Non-inclusion:**

- Refers to limitations due to the illness symptoms (‘dysfunctions’) and distress expressed by worries or concerns about the condition; this concept corresponds with the term ‘disability’ as used in ICF.  
  
  Üstün & Kennedy, *World Psychiatry* 2009;8:82-85

- Impairments of psychosocial functioning may be present in approx. 40% of persons with schizophrenia although symptom remission (Andreasen criteria) has been achieved.


- Psychosocial functioning in schizophrenia is not invariably constant, but shows dynamic changes across the lifetime with improvements of psychosocial functioning in higher age if adequate psychosocial therapy is provided.

  Jeste et al., *Schizophr Bull* 2011;37:451-455

Functional impairments are not always present in persons with schizophrenia, and functional impairment in persons with psychosis-like experiences in the general population does not necessarily indicate schizophrenia.

Nuevo et al., *Schizophr Bull* 2010; 38:475-485
PRESENTATIONS OF SHORT DURATION

If the duration requirement of 1 month is not met:

- Appropriate diagnosis is generally Other Primary Psychotic Disorder

- Acute and Transient Psychotic Disorder is not an appropriate diagnosis for presentations similar to schizophrenia but lasting less than 1 month, unless symptoms fluctuate rapidly and other ATPD requirements are met (rapid onset, absence of negative symptoms)
ICD-11 SCHIZOAFFECTIVE DISORDER

• Simultaneously meeting requirements for Schizophrenia and a Mood episode (Depressive, Manic, or Mixed)
  • Psychotic and mood symptoms started roughly together and are present for at least 1 month

• Not longitudinal or lifelong in nature; the diagnosis only applies to the current episode of illness (different to DSM-5)

• Thus, if an individual was previously diagnosed with schizoaffective disorder, they may currently be diagnosed with schizophrenia if insufficient mood symptoms are present, or with a depressive or bipolar disorder if insufficient psychotic symptoms are present.
ICD-11 ACUTE & TRANSIENT PSYCHOTIC DISORDER

- ICD-10 subtypes of ATPD have been removed and are located in other categories of the psychotic disorder chapter.

- Represents a sudden onset (over no more than 2 weeks) of highly variable/fluctuating psychotic symptoms of brief duration (no longer than 3 months).

- Negative symptoms must not be present.

- Does not include typical schizophrenia presentation of insufficient duration.

- Following remission, the person is generally able to regain the premorbid level of functioning.
MAJOR CHANGES OF ATPD IN ICD-11

- Subcategories of “Acute and transient psychotic disorder” removed.
- “Acute schizophrenia-like psychotic disorder” and “Acute polymorphic psychotic disorder with symptoms of schizophrenia” collapsed with “Other primary psychotic disorder”.
- “Other acute predominantly delusional disorder” now referred to as “Delusional disorder”.

ICD-10

- F22 Persistent Delusional Disorders
- F23 Acute and Transient Psychotic Disorders
- F24 Induced delusional disorder

ICD-11

- Schizoaffective Disorder
- Acute and Transient Psychotic Disorder
- Schizotypal Disorder
- Delusional Disorder
- Other Primary Psychotic Disorder

- F23.0 Acute polymorphic psychotic without symptoms of schizophrenia
- F23.1 Acute polymorphic with symptoms of schizophrenia
- F23.2 Acute Schizophrenia-like
- F23.3 Other acute predom. delusional
ICD-11 SCHIZOTYPAL DISORDER

- Largely unchanged in ICD-11 compared to ICD-10
- Enduring pattern of unusual speech, perceptions, beliefs, and behaviors not of sufficient intensity to meet requirements for another psychotic disorder
- Symptoms are present continuously or episodically for at least 2 years
- Symptoms cause distress or impairment
ICD-11 DELUSIONAL DISORDER

- Definition requires presence of a delusion or set of related delusions, typically for at least 3 months, with absence of other psychotic features (except possibly hallucinations consistent with delusional content).

- Apart from actions and attitudes related to the delusion, affect, speech and behavior are typically unaffected.

- ICD-10 Induced Delusional Disorder has been eliminated as a separate category and is included in ICD-11 Delusional Disorder.
SECONDARY AND RESIDUAL CATEGORIES

- Substance-induced psychotic disorders
- 6E61 Secondary psychotic syndrome
  - 6E61.0 ... with hallucinations
  - 6E61.1 ... with delusions
  - 6E61.2 ... with hallucinations and delusions
  - 6E61.3 ... with unspecified symptoms
    - Add detail by postcoordination: Has causing condition (Code also) ...

- 6A2Y Other specified primary psychotic disorders
- 6A2Z Schizophrenia or other primary psychotic disorders, unspecified
Psychotic symptoms may occur during Moderate or Severe Depressive, Manic, or Mixed episodes, often with content consistent with mood state.

However, they occur only during the mood episode, and do not meet duration requirement for Schizophrenia so as to qualify for Schizoaffective Disorder (i.e., duration is <1 month).
Psychotic experiences may occur in the general population, but do not last long enough to qualify for a disorder and/or are not accompanied by functional impairment.

Cultural variations in experience may appear psychotic; determine if the experience is normative or accepted within the culture before assigning a diagnosis.
DISCUSSION

Q & A