Psychotic Disorders in ICD–11

W. Gaebel1,2; J. Zielasek1,2; P. Falkai3

1Department of Psychiatry and Psychotherapy, Medical Faculty, Heinrich-Heine University, Düsseldorf, Germany; 2WHO Collaborating Centre for Quality Assurance and Empowerment in Mental Health, Düsseldorf, Germany; 3Department of Psychiatry and Psychotherapy, Ludwig Maximilians University, Munich, Germany

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Summary
For the development of ICD–11, the World Health Organization (WHO) has inaugurated a Working Group on the Classification of Psychotic Disorders (WGPD). A range of changes of the classification of primary psychotic disorders was developed by this group. While DSM–5 was published in 2013, the ICD–11 proposals are currently undergoing internet-based and clinical field trials and the final version is due in 2017. Among the major changes suggested by the WGPD for ICD–11 are the chapter titles, the replacement of the current schizophrenia subtypes by a number of symptom specifiers, a new set of course specifiers harmonized with DSM–5, transsectional diagnostic criteria for schizoaffective disorder, and a reorganization of the acute and transient psychotic disorders and delusional disorders.

Schlüsselwörter
Klassifikation, psychische Störungen, ICD–11, DSM–5, Feldversuche

Zusammenfassung

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criteria, diagnostic guidelines, temporal and severity specifiers, differential diagnosis, course features, comorbidities, and culture- and gender-related aspects. Within these efforts to revise the International Classification of Diseases (ICD-10; 24), a Working Group on the Classification of Psychotic Disorders (WGPD, Chair: W. Gaebel) was formed consisting of an international expert panel from all global regions of the WHO. The group developed a number of suggestions for revised classification criteria of schizophrenia and other primary psychotic disorders (6), which are currently undergoing internet-based field trials and – in the foreseeable future – clinic-based field trials.

**Chapter title and metastructure**

For ICD-11, the suggestion will be to rename the chapter „Schizophrenia and Other Primary Psychotic Disorders“. The term „primary“ was added to differentiate these psychotic disorders from psychotic disorders associated with a general medical condition or substance abuse or withdrawal (which would be considered non-primary psychotic disorders). Table 1 gives the current version of the metastructure of the chapter. The most pronounced differences are due to the inclusion of the non-primary psychotic disorders in DSM-5. Another aspect is schizotypal disorder, which is considered a personality disorder in DSM-5 (but will remain a primary psychotic disorder in ICD-11 as it had been in ICD-10 already). Finally, for the brief psychotic disorders, ICD-11 uses a different concept (acute and transient psychotic disorders).

**Schizophrenia**

The symptom list for schizophrenia in ICD-11 was revised and now demands that at least two of the following symptom categories have been present during a period of at least one month. One of the present symptoms should be of the core symptoms (a-d):

a) persistent delusions of any kind;
b) persistent hallucinations in any modality;
c) thought disorder (disorganization, e.g., tangentiality, loose associations), resulting in severe cases in incoherence or irrelevant speech, or neologisms;
d) distortions of self-experience (e.g. thoughts are no more felt to be generated by the subject, up to the point of passivity phenomena, such as thought insertion or thought withdrawal);
e) negative symptoms such as apathy and anhedonia, paucity of speech, and blunting of emotional expressions (not due to depression or to medication);
f) disorganized behaviour, including odd, eccentric, aimless and agitated activity;
g) psychomotor disorders (e.g., excitement, posturing, or waxy flexibility, negativism, mutism, stupor).

<table>
<thead>
<tr>
<th>ICD-11</th>
<th>DSM-5</th>
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<tbody>
<tr>
<td>7A50 Schizophrenia and other primary psychotic disorders</td>
<td>Schizophrenia spectrum and other psychotic disorders</td>
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<td>7A51 Schizoaffective disorder</td>
<td>Schizoaffective disorder</td>
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<td>7A52 Schizotypal disorder</td>
<td>Schizotypal personality disorder</td>
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<td>7A53 Acute and transient psychotic disorder</td>
<td>Brief psychotic disorder</td>
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<tr>
<td>7A54 Delusional disorder</td>
<td>Delusional disorder</td>
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<tr>
<td>7A5Y Other specified schizophrenia and other primary psychotic disorders</td>
<td>Other specified schizophrenia spectrum and other psychotic disorders</td>
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<td>7A5Z Schizophrenia and other primary psychotic disorders, unspecified</td>
<td>Unspecified schizophrenia spectrum and other psychotic disorders</td>
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<td>Schizophreniform disorder</td>
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<td>Substance/medication induced psychotic disorder</td>
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<td>Psychotic disorder due to another medical condition</td>
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<td></td>
<td>Catatonia associated with another mental disorder (catatonia specifier)</td>
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<td></td>
<td>Catatonic disorder due to another medical condition</td>
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<td></td>
<td>Unspecified catatonia</td>
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Table 1

The metastructure of primary psychotic disorders in ICD-11 and DSM-5 as of January 2015. For better comparability of DSM-5 with ICD-11, the DSM-5 entries are ordered in this table following the ICD-11 order. Note that the chapter in ICD-11 only contains the primary psychotic disorders, whereas the chapter in DSM-5 also contains the non-primary psychotic disorders.
First-rank symptoms (FRS) are thus deemphasized in ICD-11 based on the lack of evidence for the specificity of FRS for schizophrenia and their debatable prognostic significance (8, 16, 17). A similar step was taken in DSM-5 and the omission of the subtypes in DSM-5 did not lead to altered interpretations of previous psychopathological clinical trials and a retrospective analysis of such trial results also showed that the previous clinical subtypes did not correlate sufficiently with therapeutic responses. These were rather related to the dimensional symptom profile of psychotic disorders (12). A major difference between ICD-11 and DSM-5 is the duration criterion, which is one month in ICD-11 and 6 months in DSM-5. The shorter duration criterion of ICD-10 is retained based on the high stability of the diagnosis over time compared to the DSM-IV diagnosis (19) and the lack of sufficient evidence for a longer duration criterion (reviewed by [9]).

The ICD-11 working group suggested to replace the classical subtypes by six symptom specifiers (positive, negative, depressive, manic, and psychomotor symptoms, and cognitive impairment), each coded separately, and a similar system was introduced in DSM-5 comprising assessments of hallucinations, delusions, disorganized speech, abnormal psychomotor behaviour, negative symptoms, impaired cognition, depression and mania. Cognitive impairments as part of the symptom specifiers will be newly introduced to the spectrum of schizophrenia symptoms given their high importance for the clinical course (7, 14). An open issue to be addressed in the field trials of ICD-11 is the operationalization of the rating of the symptoms specifiers (yes-no rating vs. a multi-level Likert-type scale). DSM-5 uses a five-point Likert-type scale, which leads to a large number of potential specifier denominations. The course specifiers have been reformulated in DSM-5 and distinguish between first episode and multiple episode cases, full and partial remission, as well as continuous cases, and a harmonized suggestion has been put forward in ICD-11 (Table 2). These course criteria allow the clinically important distinction between a first episode and recurrent episodes, and whether the current state is in an acute episode, or in full or partial remission. Usually, an observation period of one year will be necessary to diagnose the multiple episode or the continuous subtypes.

In line with the WHO position that functional criteria should not be included among the clinical criteria unless they are absolutely indispensable, the WGPD has not included functional impairment as a necessary criterion (18).

### Schizoaffective disorder

The diagnosis of schizoaffective disorder in ICD-11 was suggested by the WGPD to require that symptom criteria of schizophrenia (e.g., delusions, hallucinations) and mood disorder (depressive or manic episode) of moderate or severe degree must be met simultaneously or within a few days of each other for 4 weeks each (6). These criteria stress the transsectional diagnostic approach and avoid the diagnostic uncertainties which may be associated with a more longitudinal diagnostic approach, as was chosen in DSM-5, in which a lifetime assessment of symptoms is necessary (10). It will be important for future research to show which of these alternative approaches in ICD-11 and DSM-5 result in greater diagnostic accuracy (test-retest reliability, inter-rater reliability). Important arguments for the transsectional classification in ICD-11 were the easier feasibility of a transsectional approach compared to a longitudinal (life-time) approach as in DSM-5, and the immediate therapeutic consequences of noting simultaneous symptoms of both schizophrenia and an at least moderately severe mood disorder in a patient.

### Acute and transient psychotic disorders (ATPD) and delusional disorders

Substantial changes of the metastructure of the „Acute and transient psychotic disorders” (ATPD) were implemented. The essential clinical features (acute onset, brief duration and polymorphic clinical presentation; [11]) were preserved, but to better acknowledge the psychopathological distinction between schizophrenic and delusional aspects, the ICD-10 F23 categories were reorganized. A recent Danish register-based study on the epidemiology, course and outcome of ATPD using the ICD-10 diagnostic criteria also suggested that the distinction between ATPD without symptoms of schizophrenia and the subtypes with symptoms of schizophrenia or delusions was warranted (3). ICD-10 F23.0 „Acute polymorphic psychotic disorder without symptoms of schizophrenia” became the basis of the clinical guideline for ICD-11 ATPD with a duration of up to three months. The delusional subtype (F23.3) was

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**Table 2** Course specifiers for psychotic disorders (harmonized between DSM-5 and ICD-11).

<table>
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<tr>
<th>Specifier</th>
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<tr>
<td>First episode, currently in acute episode</td>
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<td>First episode, currently in partial remission</td>
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<tr>
<td>First episode, currently in full remission</td>
</tr>
<tr>
<td>Multiple episodes, currently in acute episode</td>
</tr>
<tr>
<td>Multiple episodes, currently in partial remission</td>
</tr>
<tr>
<td>Multiple episodes, currently in full remission</td>
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<tr>
<td>Unspecified</td>
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moved to the revised ICD-11 category „Delusional Disorder“. An important aspect is the instability of the ATPD diagnosis over time, leading into different diagnoses like bipolar disorder or schizophrenia in approximately half of the cases over the course of 5–10 years, with considerable intercultural differences (3, 22). It is to be hoped that the prognostic value of the novel ICD-11 criteria for ATPD will be improved and future register based studies may be necessary to address this question. In DSM-5, “brief psychotic disorder” substitutes for the ATPD category in that it allows the classification of persons with schizophrenia symptoms not fulfilling the duration criterion of 6 months. However, the polymorphic psychotic clinical picture of ATPD is not covered by DSM-5 criteria.

**Schizotypal disorder**

No major changes were suggested for this mental disorder.

**Attenuated psychosis syndrome**

The WGPD did not include this category among the psychotic disorders, but suggests encouraging further research in this area. Therefore, this category may be placed among the mental health states requiring further scientific study, a proposed special section of ICD-11. The new category opens important questions as to the border between health and disease, and the danger of overdiagnosing persons who have attenuated psychotic symptoms (discussed by [2]). The addition of this category in DSM-5 has already inspired research projects and one major advantage is that the unified DSM-5 criteria will be used, making comparability of the results easier than before, when different research groups had used widely different criteria. A recent population-based study in Switzerland (age group 16–40 years) indicated that only 0.3% of the population fulfilled the diagnostic criteria of the DSM-5 attenuated psychosis syndrome. However, the authors proposed that a revision of the restrictive onset criterion was warranted since it excluded a number of persons who experienced and were distressed by attenuated psychosis symptoms from mental healthcare (20).

**Other primary psychotic disorders and unspecified primary psychotic disorders**

Patients with symptoms which do not reach the symptom or duration criteria of any specific primary psychotic disorder mentioned above may be classified among the „other primary psychotic disorders“. Unspecified primary psychotic disorders are coded only if there is not sufficient information, the examination is incomplete, or as a temporary diagnosis before further information is available.

**Catatonia**

Catatonia occurs in a range of mental disorders including schizophrenia, mood disorders, and general medical conditions. DSM-5 made several major changes for the classification of catatonia by utilizing a single set of criteria to diagnose catatonia and include catatonia as a clinical specifier for schizophrenia, mood disorders and other primary and secondary psychotic disorders (21). Also, a category of “unspecified catatonia” was introduced. However, recent research suggests that these changes did not improve the classification but suggest that a broad clinical description including both the hyperactive and the underactive symptoms of catatonia may be warranted (23). In ICD-11, the current suggestion includes the symptoms of catatonia among the clinical psychomotor specifiers.

**Comparison of ICD-11 and DSM-5**

There is a range of points of harmonization between both classification systems, although several differences will probably remain. Both classification systems take important steps into the direction of dimensional symptom and severity assessments. Further similarities between ICD-11 and DSM-5 are the reduced role of first-rank symptoms in the diagnosis of schizophrenia, and the replacement of the clinical subtypes of schizophrenia with symptom specifiers („dimensional assessments“ in DSM-5 and „symptom specifiers“ in ICD-11). Both systems now propose the inclusion of cognitive impairments indicating the increased realization of the importance of cognitive impairments for the clinical course. In addition, the course specifiers have been harmonized. However, DSM-5 includes schizophreniform disorder and brief psychotic disorder, which are not included in ICD-11. The „brief psychotic disorder“ is a necessity of DSM-5 due to its long duration criterion of six months for schizophrenia and the ensuing large number of patients who do not fulfill this criterion during the initial phase of schizophrenia, but a drawback is that the polymorphic psychotic presentation are not well covered in DSM-5 compared to ICD-11 (ATPD). A further considerable difference concerns the role of functional impairments for the diagnosis of schizophrenia and mental disorders in general. Including functional impairments may lead to the exclusion of patients with symptoms of mental disorders but low levels of functional impairment...
from mental healthcare services, an issue which has not yet been systematically investigated.

Discussion

Currently, the internet-based WHO ICD-11 field trials are underway and test the clinical utility, reliability and validity of the proposed diagnostic criteria using case vignettes. These will be followed by clinic-based field-trials assessing the reliability and clinical utility of the revised classification criteria. Based on the results of these field trials as well as on public and expert comments following the publication of the ICD-11 beta version, the classification criteria may be adjusted before final publication in 2017. Psychiatrists, psychologists and others involved in mental healthcare and interested in collaborating in the internet-based field trials can still register with WHO (http://www.globalclinicalpractice.net/) and review and comment the current ICD-11 beta version (http://apps.who.int/classifications/icd11/browse/l-m/en). A large number of international participants will assure that opinions from all countries using ICD-10 and ICD-11 will be considered in the revision process.

The proposed revisions in the chapter of primary psychotic disorders clearly do not reflect a paradigm shift. The diagnosis is still made on clinical grounds and genetic tests or other neurobiological endophenotypes were not added to the diagnostic criteria since these tests are currently not suitable for individual diagnostic purposes. Using the revised DSM-5 criteria in recent research projects as cited above provided important insights into the clinical consequences of the revision, but did not indicate that clinical consequences of the revision process.

The future elucidation of the etiopathogenesis of primary psychotic disorders may change this picture. Both DSM-5 and ICD-11 take steps into the direction of “dimensional” symptomatic assessments, but the next years will show whether such an elaborate but also time-consuming diagnostic system will be used in clinical practice. While it is important to provide a fine-grained psychopathological assessment of psychotic disorders to guide therapy and further diagnostic steps, there is still a large gap between the neurobiological findings and the clinical pictures. Research endeavours like the „Research Domain Criteria“ program of the National Institutes of Mental Health drive the field into the direction of elucidating the complex interrelationships between psychopathology and their neurobiological and psychological underpinnings (4).

Conflict of interest

The authors declare that they have no conflicts of interest concerning this study.

Compliance with ethical guidelines

This article contains no studies on humans or animals.

References


Correspondence to
Univ.-Prof. Dr. med. W. Gaebel
Dept. of Psychiatry and Psychotherapy
IVR-Klinikum Düsseldorf
Heinrich-Heine University
Bergische Landstr. 2
40629 Düsseldorf
Germany
Tel. (+) 49–211–922–2001
Fax (+) 49–211–922–2020
E-Mail: wolfgang.gaebel@uni-duesseldorf.de