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6A20 Schizophrenia

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders General cultural considerations for schizophrenia and other primary psychotic disorders • 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 and 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 and other primary psychotic disorders. Collateral information from family, community, religious or cultural reference groups may help clarify the diagnosis. • Ethnic minority and migrant groups are more likely than those in the general population to receive a diagnosis of schizophrenia and 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. 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 items a) to 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); 6A20 Schizophrenia and other primary psychotic disorders | Schizophrenia

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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders 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. Note: this category may also be used to designate the re-emergence of subthreshold symptoms of schizophrenia following an asymptomatic period in a person who has previously met the diagnostic requirements for schizophrenia. 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. Schizophrenia, first episode, unspecified Schizophrenia, multiple episodes • The multiple episodes specifier should be applied when there have 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. 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. 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. 6A20.01 6A20.02 6A20.0Z 6A20.1 6A20.10 6A20.11 Schizophrenia and other primary psychotic disorders | Schizophrenia

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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Note: this category may also be used to designate the re-emergence of subthreshold symptoms of schizophrenia following an asymptomatic period. Schizophrenia, continuous, in full remission • The full diagnostic requirements for schizophrenia, continuous were previously met but have not been met within the past month. • No clinically significant symptoms of schizophrenia remain. Schizophrenia, continuous, unspecified Other

specified episode of schizophrenia Schizophrenia, episode unspecified 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 6A20.22 6A20.2Z 6A20.Y 6A20.Z Schizophrenia and other primary psychotic disorders | Schizophrenia

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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Culture-related features • Cultural factors may influence the onset, symptom pattern, course and outcome of schizophrenia. For example, among migrants and ethnic and cultural minority communities, living in areas with a low proportion of their own migrant, ethnic or cultural group (low “ethnic density”) is associated with higher rates of schizophrenia. In addition, etiological or course-related factors may be affected by culture at the level of the family (e.g. level of family support or style of family interaction, such as expressed emotion) or at the societal context (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 another primary psychotic disorder may be increased among ethnic minority and immigrant groups, 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. Sex- and/or 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 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 onsets of the psychotic and mood symptoms are either simultaneous or occur 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 Schizophrenia and other primary psychotic disorders | Schizophrenia

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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 specified 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 than 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 specified primary psychotic disorder is more appropriate in such cases. Boundary with moderate or severe depressive episodes in single episode depressive disorder, recurrent depressive disorder, and bipolar type I and bipolar type II disorders 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 wrongdoing), poverty (e.g. 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 Schizophrenia and other primary psychotic disorders | Schizophrenia

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