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Letter to the Editor

Approach to refine ICD-11 acute and transient psychotic disorder (polymorphic psychotic disorder)

The forthcoming ICD-11 International Classification of Diseases will replace the current ICD-10 category of 'acute and transient psychotic disorders' (ATPDs; WHO, 1992) with 'acute polymorphic psychotic disorder' (i.e. acute and transient psychotic disorder), while the remaining subtypes featuring schizophrenic or predominantly delusional symptoms will be assimilated into other classes of the newly renamed section 'schizophrenia and other primary psychotic disorders'.

To avoid assumptions about etiology and symptom patterns, ATPDs embraced clinical conditions with polymorphic, schizophrenic or predominantly delusional features, characterized by acute onset within 2 weeks, association (or not) with 'acute stress' (i.e. bereavement, unexpected loss of partner or job, etc.) occurring within 2 weeks before the onset of symptoms, and temporal criteria shorter than 1 or 3 months as ICD-10 schizophrenia and persistent delusional disorder last at least 1 or 3 months respectively. Acute polymorphic psychotic disorder features varied delusions, hallucinations, perceptual changes, perplexity and emotional turmoil shifting daily or even faster, and refers to earlier diagnostic concepts of European Psychiatry such as *bouffée délirante* and cycloid psychosis.

The clinical characteristics of the proposed ATPD category are likely to remain the same as in acute polymorphic psychotic disorder and involve the "acute onset of psychotic symptoms that emerge without a prodrome and reach their maximal severity within two weeks. Symptoms may include delusions, hallucinations, disorganization of thought processes, perplexity or confusion, and disturbances of affect and mood. Catatonia-like psychomotor disturbances may be present. Symptoms typically change rapidly, both in nature and intensity, from day to day, or even within a single day. The duration of the episode does not exceed 3 months, and most commonly lasts from a few days to 1 month…" (WHO, 2018). Additional codes will be introduced to indicate positive, negative, depressive, manic, psychomotor and/or cognitive symptoms; yet no mention is made of association with 'stress'.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has, since its fourth edition, listed 'brief psychotic disorder', whose definition and diagnostic criteria have remained almost unchanged in DSM-5 (APA, 2013). Although this category can be compared with ICD-11 ATPD, it lasts less than 1 month, and neither the period of onset nor polymorphic symptoms is mentioned. The DSM classified under 'schizophreniform disorder' cases with typical schizophrenic symptoms and duration intermediate between brief psychotic disorder and schizophrenia (at least 6 months).

Existing studies (Castagnini and Fusar-Poli, 2017) suggest that ATPDs are rare and affect more often women or both genders almost equally, with onset in early to middle adulthood. They also are neither associated with premorbid impairments nor high family risk, at least partly overlapping with schizophrenia and bipolar disorder (Castagnini et al., 2013); yet there seems to be greater evidence of environmental risk factors as observed in developing countries and migrants. Moreover, follow-up studies revealed that ATPDs fare better than schizophrenia, though about half of cases tended to change diagnosis mainly either schizophrenia and related disorders or, to a lesser extent, affective disorders. Abrupt onset, female gender, age over 30 years, and good premorbid adjustment were reported to be associated with diagnostic stability and/or favourable outcome (Table 1).

These findings are likely to reflect the heterogeneity of the clinical features encompassed by ATPDs, as acute polymorphic psychotic disorder is found to be significantly more common in women than the diagnostic subtypes with acute schizophrenic symptoms, which instead predominate in younger men (Castagnini and Foldager, 2014). It also exhibits lower recurrence rates and greater predictive validity than the subtypes with schizophrenic and predominantly delusional features, but its consistency reaches just 54% on average over 8.8 years (Castagnini et al., 2018). In addition, polymorphic psychotic disorder is more likely to convert into affective disorders in subsequent episodes, and it will fit less easily within ICD-11 'schizophrenia and other primary psychotic disorders'.

On the nosological side, it seems also questionable whether the new ATPD category constitutes a reliable diagnosis as the field trials conducted to test the reliability and clinical utility of the proposed ICD-11 Clinical Descriptions and Diagnostic Guidelines reported that it failed to achieve established standards of reliability (Reed et al., 2018), similarly to the polymorphic subtype to which it refers to in the ICD-10 Diagnostic Criteria for Research field trials (Sartorius et al., 1995). Since it is not easy to identify cases with acute polymorphic psychotic disorder in practice, both for its rarity and little reliability, this will reduce its clinical usefulness and discourage research, an effect that will be particularly marked in developing countries where this diagnosis is more commonly used (Faiad et al., 2018).

These shortcomings highlight the need of defining "acute stress" more adequately, as it constitutes only an additional diagnostic feature and its temporal relationship to ATPDs limited to 2 weeks, and refining further the ATPD category. In keeping with the principles of symptom-based modern classification, it might benefit from incorporating the clinical features that lend themselves to easier assessment and offer, at least, greater diagnostic reliability such as acute onset, florid psychotic symptoms and early remission; yet 'polymorphic symptoms' might be added as a supplementary clinical description, and the subtypes with schizophrenic or predominantly delusional features withdrawn from classification given the lack of validity.

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Table 1
Antecedent, concurrent and prognostic validators for ICD-10 'acute polymorphic psychotic disorders' (ATPDs) and 'acute polymorphic psychotic disorder' (APPD).

Antecedent validators	
Frequency	ATPD incidence 1.4–6.7 per 100,000; prevalence 6–20% of psychotic disorders, higher rates in developing countries; APPD accounts for 20–70% of ATPDs
Age and sex	ATPD mean age range 26–37 years, lower in developing countries; APPD more common in women aged over 30 years
Premorbid functioning	ATPDs associated neither with premorbid dysfunctions nor specific personality disorder
Family morbidity	ATPD family risk lower than that for schizophrenia and bipolar disorder, partly attributable to the effect of both conditions; APPD risk associated with ATPDs and schizophrenia in family members
Environmental factors	Psychological and socio-cultural risk factors more frequently reported in developing countries and migrant populations
Concurrent validators	
Reliability	ATPD kappa = 0.74; APPD k = 0.54
Symptom type	No pathognomonic symptom; variable clinical pattern and fewer negative symptoms than schizophrenia
Biological correlates	Metabolic and neurophysiological changes of uncertain clinical meaning, no brain alterations; putative genetic loci overlapping with those for schizophrenia
Predictive validators	
Diagnostic stability	ATPD stability (~50%); APPD lower recurrence rates and greater consistency (54% over 8.8 years) than the subtypes with schizophrenic or delusional symptoms
Course and outcome	Better clinical and social outcome than schizophrenia, schizoaffective disorder and bipolar disorder
Treatment	No controlled clinical trials
Mortality	Increased mortality risk from natural and unnatural causes, particularly suicide; higher rates of suicidal behaviour associated with polymorphic symptoms

Lastly, since the ATPD category does not conform to any category used to classified short-lived psychotic disorders in DSM-5, closer overlap between the two classificatory systems will have positive implications for clinical practice, research and the wider understanding of these conditions.

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