APORIA · ISSUE THREE

03

Four Codes, One Question.

A woman has believed for nine months that her husband has been replaced. There is no thought disorder, no negative symptoms, no first-rank phenomena. F20, F22, F28, or F29. The aporia is not the patient. It is the code.

CLINICAL DILEMMAS IN PSYCHIATRY

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01 / APORIA

The patient who fits no box

A 54-year-old woman is brought to OPD by her daughter. For nine months she has insisted, with full conviction, that her husband of thirty-one years has been replaced by an impostor who looks exactly like him. The husband still lives in the house. She cooks his meals. She does not sleep in his bed. She has no auditory hallucinations. No thought disorder on examination. Affect is reactive. Self-care is preserved. Cognition is intact. She holds the belief, and only this belief, with absolute certainty. F20, F22, F28, or F29.

This is the aporia of the third issue. Psychiatry has four ICD-10 codes for primary psychotic disorder in this register, and three diagnostic systems (ICD-10, ICD-11, DSM-5) that disagree about which of them applies to a patient like this. The fault is not in the books. The patient is real, and the books are doing their job. The aporia is that the codes were built for different purposes, syndrome-defining (F20), pattern-defining (F22), residual-with-information (F28), and residual-without-information (F29), and a single patient can sit in the gap between them for years before a longitudinal answer emerges.

This issue walks the four codes in order of certainty: F20 first, because schizophrenia is the most rule-defined and the most over-applied; F22 second, because persistent delusional disorder is under-recognised in Indian practice and over-converted to F20 by reflex; F28 third, because "other specified" is the code that demands the most documentation and the least understood by trainees; and F29 fourth, because "unspecified" is a placeholder, not a diagnosis. The reference list anchors every clinical claim to the WHO ICD-11 Clinical Descriptions and Diagnostic Requirements (CDDR), DSM-5-TR, the IPS Clinical Practice Guidelines 2026, and recent (2022 to 2026) literature on diagnostic stability, late-onset delusional states, and the operational use of residual codes.

> WHAT THIS ISSUE COVERS
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> Aporia 03 maps four ICD-10 primary psychotic disorder codes against their ICD-11 and DSM-5 equivalents, walks each code from criteria to clinical reasoning to documentation template, and anchors the differential in Indian practice patterns. The frame is operational. The structure follows the codes in order of certainty (F20, F22, F28, F29), then the cross-system comparison, then the discriminators at the bedside, then the decision algorithm, then the documentation templates, then the special syndromes (Capgras, Cotard, Ekbom, Othello, folie a deux, paraphrenia), then the Indian frame, and finally the references. The piece is twelve chapters long.

Why these four, and not F21, F23, F24, F25

The ICD-10 F20 to F29 block contains ten codes. Six are excluded from this issue by design. F21 (schizotypal disorder) is a personality-spectrum category, not an acute psychotic disorder, and the differential rarely arises in the same OPD slot. F23 (acute and transient psychotic disorders) is a duration category, not a phenomenology category, and Aporia 01 already touches its borders. F24 (induced delusional disorder, folie a deux) is folded into F22 in ICD-11 and into "other specified" in DSM-5; it is treated as a sub-syndrome of F22 in this issue. F25

(schizoaffective disorder) deserves its own aporia and is mentioned only at the schizophrenia-mood borderline. F26 and F27 do not exist. The four codes that remain, F20, F22, F28, F29, define the working differential for an adult with non-organic, non-substance, non-mood-confined psychosis on a single OPD visit.

The Indian shape of the question

Two facts shape this differential in Indian practice. The first is that delusional disorder is under-diagnosed: late-onset isolated delusions in widowed women with sensory impairment are routinely coded F20 on first contact, F22 only after months of follow-up. The Hong Kong first-episode cohort followed 219 first-episode delusional disorder patients for four years and reported a 35% conversion rate to schizophrenia.[1] The conversion is real but the misclassification at first visit is larger. The second is that F28 and F29 carry different operational meanings in Indian tertiary practice than in Western coding habits: F28 is used as a holding code for atypical presentations that the local team plans to refine, and F29 is used as a documented "more information needed" tag in ED and admission settings. This issue treats both meanings as legitimate.

02 / FIELD

The four codes, structurally

The four codes are not parallel. They are stratified by the level of clinical certainty the clinician can defend in writing. F20 is a positive identification: this is schizophrenia. F22 is also a positive identification: this is persistent delusional disorder. F28 is a positive identification with a negative-space frame: this is a primary psychotic disorder but it is not F20, F22, F23 or F25. F29 is an admission of insufficient information: this is psychosis, but I cannot yet say what kind. The clinical work is to move every patient from F29 toward F20, F22, F25 or another named category over the course of follow-up.

NAMED PRIMARY · FULL SYNDROME

F20 Schizophrenia

A positive diagnosis. Characteristic psychotic syndrome with positive, negative, disorganisation symptoms, duration threshold, functional decline, and exclusion of organic, substance and mood-primary causes. Criterion-driven across ICD-10, ICD-11 and DSM-5.

NAMED PRIMARY · FOCAL PATTERN

F22 Persistent delusional disorder

A positive diagnosis. One delusion or a set of related delusions dominates the picture for at least one to three months. No formal thought disorder, no persistent hallucinations, no negative symptoms, no schizophrenia syndrome. Functioning often preserved outside the delusional system.

RESIDUAL · SPECIFIED

F28 Other nonorganic psychotic disorders

A residual category with information. Psychosis is primary, you can describe what it is and why it does not fit the named disorders, but the pattern is atypical, subthreshold, or mixed. ICD-11 calls this "other specified primary psychotic disorder."

RESIDUAL · UNSPECIFIED

F29 Unspecified nonorganic psychosis

A holding code. Psychosis is present, but information is insufficient to specify the disorder. Used in ED, admission, and first-contact settings while collateral and longitudinal data are gathered. Should be revised at the earliest opportunity.

The three diagnostic systems

The same four positions exist in all three systems, with slight terminological shifts. ICD-10 names them F20, F22, F28, F29. ICD-11 renames F22 as 6A24 Delusional Disorder (dropping "persistent" from the name) and reorganises F28 and F29 into 6A2Y "Other specified primary psychotic disorder" and 6A2Z "Schizophrenia or other primary psychotic disorder, unspecified." [2] DSM-5 keeps Delusional Disorder under the Schizophrenia Spectrum and Other Psychotic Disorders class, and uses "Other specified" and "Unspecified schizophrenia spectrum and other psychotic disorder" as the two residuals. The mapping is clean. The thresholds and emphases are not.

ICD-10 (F-CODE)	ICD-11 (CONCEPTUAL EQUIVALENT)	DSM-5 (CLOSEST EQUIVALENT)	LEVEL
F20 Schizophrenia	6A20 Schizophrenia	Schizophrenia (295.90)	NAMED, FULL
F22 Persistent delusional disorder	6A24 Delusional disorder	Delusional disorder (297.1)	NAMED, FOCAL
F28 Other nonorganic psychotic disorders	6A2Y Other specified primary psychotic disorder	Other specified schizophrenia spectrum and other psychotic disorder (298.8)	RESIDUAL, SPECIFIED
F29 Unspecified nonorganic psychosis	6A2Z Schizophrenia or other primary psychotic disorder, unspecified	Unspecified schizophrenia spectrum and other psychotic disorder (298.9)	RESIDUAL, UNSPECIFIED

The clinician's question, in order

The decision is sequential. First: is this psychosis at all (delusion, hallucination, disorganisation, catatonia)? Second: is it primary (not organic, not substance, not delirium, not mood-primary)? Third: does it meet schizophrenia criteria for the system you are using (one-month duration in ICD-10/ICD-11, six-month total disturbance with one-month active phase in DSM-5)? If yes, F20. If no, can you specify a focal delusional pattern that lacks the schizophrenia syndrome? If yes, F22. If no, can you specify what it is and why it does not fit the named disorders? If yes, F28. If no, F29, and write a reassessment date in the chart.

03 / F20

Schizophrenia

F20 is the most rule-defined and the most over-applied of the four codes. Indian first-episode psychosis cohorts repeatedly show that 25 to 35 percent of patients initially coded F20 are reclassified to F22, F25, F31 with psychotic features, or substance-induced psychosis on six-month follow-up. [3] The over-application is structural: F20 is the default code most Indian psychiatrists reach for when the patient is psychotic, primary, non-substance, non-mood, and not obviously fitting another category. Resisting that reflex is half the work of this differential.

F20 · ICD-10 / 6A20 ICD-11 / 295.90 DSM-5

Schizophrenia

PRIMARY PSYCHOTIC DISORDER · FULL SYNDROME

ICD-10 CRITERIA, OPERATIONAL

A characteristic psychotic syndrome present most of the time for at least one month, with at least one of (a) thought echo, insertion, withdrawal, broadcast; (b) delusions of control, influence, passivity; (c) hallucinatory voices commenting or discussing; (d) persistent bizarre delusions; *or* at least two of (e) persistent hallucinations of any modality; (f) breaks in train of thought, neologisms; (g) catatonic phenomena; (h) negative symptoms; (i) significant change in personal behaviour. Organic, substance and mood-confined causes excluded.

ICD-11 CRITERIA, WHAT CHANGED

The subtypes (paranoid, hebephrenic, catatonic, simple, residual) are **removed** in ICD-11. The Schneiderian first-rank symptoms are **de-emphasised** but not excluded; they are folded into the broader symptom requirement. Six symptom dimensions are added as specifiers (positive, negative, depressive, manic, psychomotor, cognitive). Course specifiers (first episode, multiple episodes, continuous) replace the older course modifiers.[2] The duration concept is retained at one month.

DSM-5 CRITERIA, WHAT DIFFERS

Two or more of (1) delusions, (2) hallucinations, (3) disorganised speech, (4) grossly disorganised or catatonic behaviour, (5) negative symptoms, with at least one being delusions, hallucinations or disorganised speech. **Marked functional decline** is Criterion B (an explicit requirement, unlike ICD). Duration is **six months total disturbance**, with at least **one month of active-phase symptoms** (or less if successfully treated). Schizoaffective and mood-with-psychosis exclusion, substance and medical exclusion. If autism spectrum or communication disorder is present, schizophrenia requires prominent delusions or hallucinations for at least one month.

> **THE DISCRIMINATOR**
>
> *F20 is a syndrome, not a list of symptoms. A patient with three years of one fixed persecutory belief, no thought disorder, no negative symptoms, no functional decline outside the delusional theme, is not F20 even if she meets the formal threshold count. The clinical judgement is that the syndrome is absent.*

WHAT THE IPS CPG 2026 EMPHASISES

The Indian Psychiatric Society 2026 Clinical Practice Guideline for schizophrenia management positions phase-based care: acute (symptom remission and safety), continuation (six to twelve months of maintenance at minimum effective dose), and maintenance (relapse prevention). Second-generation antipsychotic monotherapy is first line in first-episode psychosis. Clozapine consideration follows two adequate antipsychotic trials. LAI is recommended proactively, not as a last resort, where nonadherence or relapse pattern indicate. ECT remains relevant for catatonia, severe affective psychosis, and selected treatment-resistant cases.[4]

WHAT DISCRIMINATES F20 FROM F22 AT THE BEDSIDE

- **Formal thought disorder** on examination, present in F20, absent in F22.
- **Negative symptoms**: blunted affect, alogia, avolition. Present in F20, absent in F22.
- **Functional decline outside the delusional theme**: broad in F20, narrowly preserved in F22.
- **Multiple delusional themes or shifting content**: F20. A single encapsulated theme, F22.
- **Persistent hallucinations not tied to the delusional content**: F20. Tactile or olfactory hallucinations *congruent* with the delusion (worms in delusional infestation, smell in olfactory reference), F22.
- **Age of onset**: F20 typically late teens to early thirties; F22 typically thirties to seventies with a late-onset peak in women.

WHAT DISCRIMINATES F20 FROM F28

The honest answer is duration and atypicality. A patient with clear primary psychotic phenomena that do not meet the schizophrenia syndrome (atypical, subthreshold, mixed) is coded F28 if the clinician can articulate what the pattern is and why it does not fit F20. The trap is using F28 as a hedge for early F20 when the duration threshold has not yet been crossed; F23 is the correct hedge for short-duration cases, not F28.

SCHNEIDERIAN FIRST-RANK SYMPTOMS, WHERE THEY SIT NOW

Schneider's 1959 list (thought insertion, withdrawal, broadcast; voices commenting, voices arguing; somatic passivity; delusional perception; made feelings, impulses, acts) was historically treated as pathognomonic of schizophrenia. Subsequent work showed prevalence of one or more FRSs at 8 to 28 percent in bipolar disorder, 10 to 25 percent in major

depression with psychotic features, and 15 to 30 percent in schizophrenia. [5] ICD-11 and DSM-5 both de-emphasise FRSs as a diagnostic shortcut. They retain viva relevance and remain useful as a phenomenological vocabulary, but they are not a diagnostic test.

04 / F22

Persistent delusional disorder

F22 is the under-diagnosed code of the four. Indian OPD samples consistently report a schizophrenia to delusional disorder ratio of roughly 20 to 1, which is higher than the global figure and almost certainly reflects under-recognition rather than true epidemiology. [6] Late-onset isolated delusions in widowed women with sensory impairment are the prototypical missed case. The Roth phenotype, onset after forty-five, often after sixty, female predominance, deafness or low vision, social isolation, persecutory or referential content, is one of the most reliable clinical patterns in psychiatry and one of the most reliably miscoded.

F22 · ICD-10 / 6A24 ICD-11 / 297.1 DSM-5

Persistent delusional disorder

PRIMARY PSYCHOTIC DISORDER · FOCAL DELUSIONAL PATTERN

ICD-10 CRITERIA, OPERATIONAL

One delusion or a set of related delusions dominates the clinical picture, is usually long-standing (at least three months in clinical guideline tradition), and is not better explained by organic disease, substance use, schizophrenia, or persistent mood disorder. [7] The delusion is the disorder. Hallucinations may be present but not persistent and not schizophrenia-like (typically content-congruent: tactile in infestation, olfactory in reference). No formal thought disorder. No negative symptoms. No persistent affective syndrome. F22.0 is delusional disorder proper; F22.8 includes involutional paranoid state and paraphrenia (late); F22.9 is unspecified.

ICD-11 CRITERIA, WHAT CHANGED

Renamed to plain **Delusional disorder (6A24)**: "persistent" is dropped from the name but the duration requirement is now explicit at three months. Bizarre delusions are **permitted** if no other schizophrenia features are present, closing a long-standing F22/F20 grey zone where bizarre content automatically pushed coding to schizophrenia. Hallucinations are allowed only when content-congruent with the delusion. Symptom-themed subtypes (persecutory, grandiose, jealous, somatic, erotomanic) drop as formal codes and are described in the text. Course specifiers are added. Paraphrenia and induced delusional disorder are no longer separate codes, they collapse into 6A24 or 6A2Y. [2]

DSM-5 CRITERIA, WHAT DIFFERS

Criterion A: one or more delusions for at least **one month** (shorter than ICD). Criterion B: Criterion A for schizophrenia **never met**. Criterion C: functioning **not markedly impaired** and behaviour not obviously bizarre. Criterion D: any mood episodes brief relative to the delusional period. Criterion E: substance, medical and better-explanation exclusion. Specify subtype: **erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified**. Specify with bizarre content if delusions are clearly implausible (the bizarre/non-bizarre specifier was retained from DSM-IV but broadened, bizarre delusions in the absence of other schizophrenia symptoms still qualify for delusional disorder). [8]

> THE DISCRIMINATOR
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> *F22 is one fixed belief in a patient whose other faculties remain intact. If the affect is reactive, the thought form is preserved, the functioning is preserved outside the delusional theme, and the belief has held for three months or longer, F22 is the diagnosis, even if the content is bizarre.*

THE SUBTYPES, WITH THEIR CLINICAL SIGNATURES

- **Persecutory**: the most common subtype. Believes others are plotting, poisoning, harassing, defaming. Often litigious; legal correspondence to police, courts, regulators. Functioning preserved outside the persecutory frame.
- **Grandiose**: special talent, identity, relationship to a deity or famous figure. Religious avatars common in Indian samples; differentiate from culturally sanctioned *bhakti* using conviction, distress, preoccupation, and functional impact.

- **Jealous (Othello syndrome)**: partner is unfaithful. Often comorbid alcohol use disorder, frontal pathology, stimulant use. High homicide risk. Indian forensic samples repeatedly link to alcohol dependence.
- **Somatic**: bodily function, sensation, appearance. Includes delusional infestation (Ekbom), delusional halitosis, delusional dysmorphia. Patients present first to dermatology, ENT, or cosmetic surgery. The matchbox sign (specimens brought to the consultation) is classic for Ekbom.
- **Erotomanic (de Clerambault)**: another, often higher-status person is in love with the patient. Three phases: hope, spite, resentment. Forensic risk concentrates in spite and resentment.
- **Mixed**: two or more themes coexist without one dominating.

THE EPONYMIC DELUSIONAL SYNDROMES

- **Capgras (1923)**: *l'illusion des sosies*; familiar person replaced by impostor. Right frontotemporal dysfunction; 73% co-occur with schizophrenia, but also Lewy-body dementia, post-TBI, and primary delusional disorder.[9] The case in the lede of this issue is a Capgras presentation.
- **Cotard (1880)**: *delire des negations*; nihilistic delusion of being dead, decaying, organs missing. Strong association with psychotic depression; responds to ECT. Less commonly seen in F22 proper than in mood-with-psychosis.
- **Ekbom (1938)**: delusional infestation. Coded under 6A24 in ICD-11 as a somatic-theme variant. The matchbox sign is pathognomonic. Best evidence: risperidone or olanzapine first line; pimozide historical first line, now reserved where ECG monitoring and access permit.[10]
- **Folie a deux / induced delusional disorder**: F24 in ICD-10, dropped as separate category in ICD-11 (now coded as 6A24 or 6A2Y in each affected individual). Inducer and induced. Separation of the induced person often resolves the induced delusion within weeks.
- **Paraphrenia (Kraepelin, 1913)**: chronic systematised delusions and hallucinations with **preserved personality and affect**, no deterioration. Kraepelin separated it from dementia praecox on that basis. Modern Indian usage tends to follow this Kraepelinian sense, often applied to middle-to-late life cases that do not fit F20 or F22 cleanly.
- **Late paraphrenia (Roth, 1955)**: onset after forty-five, mostly after sixty; paranoid delusions with or without auditory hallucinations; no negative symptoms or personality decline; female predominance; sensory deprivation (deafness) and social isolation as risk factors. The international consensus retired the term in 2000 in favour of **Late-Onset Schizophrenia (onset 40-60)** and **Very-Late-Onset Schizophrenia-Like Psychosis (over 60)**, with the latter responding to lower antipsychotic doses (twenty-five to fifty percent of adult dose).[11]

TREATMENT, ANCHORED TO CURRENT EVIDENCE

There are **no RCTs** in delusional disorder. The treatment literature is observational, case-series-heavy, and built around Alistair Munro's foundational work on monosymptomatic hypochondriacal psychosis at Queen's University, Kingston.[12] Munro established that delusional disorder is a treatable condition, not a chronic hopeless state, and that pimozide produced striking response in delusional infestation and dysmorphic variants. The Munoz-Negro and Cervilla 2016 PRISMA systematic review of 385 cases reported overall good response in approximately 33.6%, with FGAs marginally outperforming SGAs (39% vs 28%); selection bias is heavy and the figures should be read as approximate.[13] The strongest real-world data is the Lahteenvuo Swedish national cohort of 9,076 patients with delusional disorder, which showed any antipsychotic reduced psychiatric hospitalisation (adjusted hazard ratio 0.4 to 0.6), with LAIs and clozapine producing the largest reductions; no clear class advantage for FGAs over SGAs in hard outcomes.[14] Practical Indian first-line: risperidone 2 to 6 mg or olanzapine 5 to 15 mg; escalate to LAI risperidone or paliperidone when adherence is poor (the norm in this group, who deny illness). Aripiprazole is a reasonable second-line option, particularly for somatic-type and for prolactin-sensitive patients. Pimozide remains a defensible choice in dermatology-referred Ekbom cases where ECG monitoring is available, but is no longer first line.

PROGNOSIS, ANCHORED TO CURRENT EVIDENCE

The Hui 2023 Hong Kong four-year follow-up cohort is the single most useful prognostic dataset: 65% of first-episode delusional disorder patients still met delusional disorder criteria at four years; 35% converted to schizophrenia. Conversion predictors were younger onset, presence of any hallucination at baseline, and poor premorbid functioning.[1] Functioning is better preserved than in schizophrenia: occupational and social roles are often maintained outside the encapsulated delusional system, and hospitalisation rates are lower. Symptom persistence is the rule rather than the exception; full symptomatic remission is uncommon, but behavioural containment is achievable. Family burden is high and

characteristically focal, partners and children of persecutory and jealous types live under chronic accusation. Forensic risk concentrates in jealous (Othello), erotomanic (stalking, post-rejection violence) and persecutory (litigious, sometimes assaultive) types.

05 / F28

Other nonorganic psychotic disorders

F28 is the residual code that requires the most documentation and is the least understood by trainees. It is not a hedge code. It is not a placeholder. It is a positive identification of a primary psychotic disorder that does not fit the named categories, with the clinician committing in writing to what the disorder is and why it does not fit. ICD-11 renames it "Other specified primary psychotic disorder" (6A2Y) to emphasise the specification requirement, and DSM-5's "Other specified schizophrenia spectrum and other psychotic disorder" requires the same, the reason for the residual code must be stated in the chart. F28 without specification is a documentation failure.

F28 · ICD-10 / 6A2Y ICD-11 / 298.8 DSM-5

Other nonorganic psychotic disorders

RESIDUAL · SPECIFIED

OPERATIONAL DEFINITION

A primary, non-organic, non-substance, non-mood-confined psychotic disorder that does not meet criteria for any of the specifically defined disorders in F20-F25. The clinician has enough information to commit to "this is primary psychosis" and to specify what the pattern is, but the pattern fails the rule-set for F20, F22, F23, F24 or F25. The category is informational, not provisional. The provisional code is F29.

WHEN CLINICIANS ACTUALLY USE F28 (HIGH-YIELD)

- **Chronic hallucinatory psychosis**: persistent hallucinations as the dominant clinical feature, without the full schizophrenia syndrome, without a focal delusional system meeting F22.
- **Autoscopic phenomena**: heautoscopy, doppelganger experiences, out-of-body phenomena occurring in clear consciousness and persisting as a primary psychotic syndrome.
- **Sensitive Beziehungswahn of Kretschmer**: paranoid sensitivity reaction with referential and persecutory features in a sensitive personality, not meeting the duration or systematisation of F22 or the syndrome of F20.
- **Monosymptomatic states** not captured by F22 (which historically required "persistence"), particularly when the duration is between one and three months in ICD-10 framing.
- **Culture-related or atypical psychoses** with primary character, where organic and substance causes are excluded, mood primacy is excluded, and the pattern is not captured by the main ICD-10 buckets.
- **Atypical mixed psychoses** with features of more than one named category, where no single category dominates.

> DSM-5 SPECIFIER CONVENTION
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> *"Other specified" requires the clinician to provide the reason. Examples: "persistent auditory hallucinations" (without other criteria); "delusions with significant overlapping mood episodes"; "attenuated psychosis syndrome" where used. The chart entry must read: 298.8 / 6A2Y Other specified [disorder name], followed by the specifier.*

WHAT TO DOCUMENT, VERBATIM

- Which psychotic symptoms are present, in what modality, with what duration.
- What you have ruled out (organic, substance, delirium, mood-primary).
- Why it is not F20 (which schizophrenia criterion is not met).
- Why it is not F22 (single-delusion focality not present, or schizophrenia features present).
- Why it is not F23 (duration exceeds the acute and transient threshold, or onset was not sudden).
- Why it is not F25 (mood syndrome does not meet schizoaffective threshold).

- The specifier for what the pattern actually is.
- The follow-up plan and reassessment timepoint.

DIAGNOSTIC STABILITY

Castagnini and colleagues' long-term Danish register follow-up of ICD-10 F23 and adjacent residual codes showed substantial diagnostic shift over five to ten years: roughly one-third of F23 cases converted to schizophrenia, mood disorder, or schizoaffective disorder, with smaller proportions to F22 and persistent F28.[15] Indian longitudinal data is sparser, but consistent: residual codes are intermediate stops on the way to a named diagnosis, not endpoints. The clinician using F28 should expect to revise the code over the next twelve to twenty-four months.

06 / F29

Unspecified nonorganic psychosis

F29 is a placeholder, not a diagnosis. It is the code you use when the patient is psychotic, you cannot yet rule out organic and substance causes, the history is insufficient or unreliable, the duration is unclear, or the assessment is too brief for a defensible specification. F29 is a defensible code only when it is paired with a written reassessment plan. F29 carried indefinitely without revision is a documentation failure.

F29 · ICD-10 / 6A2Z ICD-11 / 298.9 DSM-5

Unspecified nonorganic psychosis

RESIDUAL · UNSPECIFIED

OPERATIONAL DEFINITION

Psychosis is present. The information needed to classify the disorder into a specific category (F20, F22, F23, F25, F28, F30-F33 with psychotic features, F0x organic psychosis, F1x substance-induced psychosis) is not yet available. Use is provisional and should be revised at the earliest opportunity.

WHEN TO USE F29 (AND WHEN NOT)

- **Use:** duration is unclear (no reliable timeline; collateral history awaited); substance and organic causes not yet excluded; patient too unwell or uncooperative to elicit detailed phenomenology; first contact or emergency setting where diagnosis is genuinely provisional.
- **Do not use:** as a hedge for early F20 when you have enough information to commit (use F23 if duration is short, F28 if pattern is specifiable but atypical, or commit to F20 if criteria are met); as a placeholder you forget to revise (every F29 needs a reassessment date written in the chart).

WHAT MAKES F29 DEFENSIBLE (WHAT TO WRITE)

- "Provisional diagnosis: F29 nonorganic psychosis, insufficient information to specify."
- The immediate differentials being considered (typically F20, F22, F23, F25, F31 with psychotic features, F1x substance-induced).
- The medical and substance exclusions being conducted (vitals, neuro exam, CBC, RFT, LFT, electrolytes, glucose, TSH, B12/folate if indicated, urine toxicology where feasible, pregnancy test when relevant, ECG and imaging when indicated).
- The plan for reassessment: timepoint (typically one to seven days inpatient, three to seven days outpatient), what new information is being sought (collateral history, prior records, substance timeline, premorbid functioning, mood timeline), and the code-revision intent.

> VIVA ONE-LINER
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> *F28: psychosis is primary and assessed, but doesn't fit the named categories, other specified. F29: psychosis is present but details are insufficient, unspecified (provisional).*

THE TRAJECTORY OUT OF F29

The clinical work after coding F29 is to gather the information that allows revision. At one week, substance and medical exclusions plus clearer phenomenology typically permit a move to F20, F22, F23, F28 or another named code. At four to six weeks, the response to an adequate antipsychotic trial provides additional information. At six months (DSM-5 schizophrenia duration threshold), continuous disturbance permits a defensible F20 diagnosis if criteria are met. F29 carried beyond three months should trigger a senior review of why specification has not been possible.

07 / CROSS-SYSTEM

How the three books disagree

The three books (ICD-10, ICD-11 CDDR, DSM-5-TR) agree on the four-code architecture but disagree on thresholds, emphases, and what is privileged at the bedside. The disagreements matter for both the viva and the chart.

FEATURE	ICD-10	ICD-11 (CDDR)	DSM-5-TR
Overall style	Clinical guidelines plus categorical diagnoses; F28 and F29 as residual categories	Clinical utility plus specifiers; stronger emphasis on symptom dimensions and course	Operational criteria; explicit symptom counts, functional decline, duration thresholds
Schizophrenia duration	~1 month characteristic symptoms (guideline tradition)	Duration concept retained at 1 month; course specifiers add detail	≥6 months total disturbance plus ≥1 month active phase (or less if treated)
Functional decline	Expected and important but not always a strict criterion	Considered clinically; specifiers capture course and impairment	Explicit requirement (Criterion B)
First-rank symptoms	Historically emphasised as strongly suggestive of F20	De-emphasised; broader dimensional approach	Not privileged; counted within delusions, hallucinations, disorganisation
F22 / Delusional disorder duration	Usually ≥3 months (guideline tradition)	≥3 months (explicit)	≥1 month
Bizarre delusions in F22	Tend to push coding to F20	Permitted in 6A24 if no other schizophrenia features	Permitted in delusional disorder with "bizarre content" specifier
Schizophrenia subtypes	Paranoid, hebephrenic, catatonic, simple, residual	Removed; replaced by symptom dimension specifiers	Removed in DSM-5; specifiers for course used instead
Residual specified vs unspecified	F28 (specified) vs F29 (unspecified)	6A2Y (other specified primary psychotic disorder) vs 6A2Z (unspecified primary psychotic disorder)	Other specified (reason given) vs Unspecified (reason not given or unable to be given)
Paraphrenia, induced delusional disorder	F22.8, F24 (separate)	Folded into 6A24 or 6A2Y; no separate codes	Folded into delusional disorder or other specified

What this means at the bedside

The three books shake out to three operational rules. The duration threshold for schizophrenia is one month in ICD and six months in DSM, with one month of active-phase symptoms in both. The functional decline requirement is explicit in DSM, expected in ICD-11, and traditionally implied in ICD-10. The Schneiderian first-rank symptoms are no longer a diagnostic shortcut in any of the three books, though they retain phenomenological vocabulary and viva relevance. If the Indian setting uses ICD-10 for billing and ICD-11 (CDDR) or DSM-5 for clinical formulation, the common pattern in tertiary centres, the chart should accommodate both, with the F-code for billing and a parallel formulation narrative anchored in the dimensional language of ICD-11.

08 / DISCRIMINATORS

The four-way comparison at the bedside

This is the table to remember. The four codes have characteristic patterns across eight clinical variables. The pattern is not always unambiguous in any single patient, but the central tendency is clear and is what makes the differential possible without a longitudinal view.

VARIABLE	F20 SCHIZOPHRENIA	F22 DELUSIONAL DISORDER	F28 OTHER SPECIFIED	F29 UNSPECIFIED
Psychotic core	Full syndrome: delusions + hallucinations + disorganisation + negative	Single or related delusion(s) only	Atypical, subthreshold, or mixed psychotic features	Psychosis confirmed but pattern unclear
Hallucinations	Persistent, often auditory verbal, content-varied	Absent or content-congruent only	May be the dominant feature without other syndrome elements	May be present, modality may be unclear
Thought disorder	Present (formal: derailment, neologism, blocking)	Absent	Usually absent or mild	May or may not be present (insufficient examination)
Negative symptoms	Present (blunted affect, avolition, alogia, anhedonia)	Absent	Absent or mild	Indeterminate
Duration	≥1 month (ICD); ≥6 months total (DSM)	≥3 months (ICD); ≥1 month (DSM)	Variable; duration is not the issue	Unclear
Functioning	Broad decline	Preserved outside delusional theme	Variable; often impaired by the specific symptom pattern	Indeterminate
Age of onset	Late teens to early 30s (modal)	30s to 70s; late-onset peak in women with sensory impairment	Any age; pattern-dependent	Any
Treatment response	Antipsychotic monotherapy; consider LAI; clozapine for TRS	Antipsychotic; partial response common; LAI when nonadherent (the norm)	Antipsychotic trial; treat as primary psychosis; reassess at 4-6 weeks	Start treatment for the syndrome while gathering information

09 / ALGORITHM

The decision in five steps

01 **Is there psychosis?** Delusions, hallucinations, formal thought disorder, grossly disorganised behaviour, or catatonia. If none → not a code in this block.

`Yes →` proceed to Step 02.

02 **Is it primary?** Rule out organic causes (delirium, dementia, neurological disease, autoimmune encephalitis, endocrine and metabolic disturbance, seizure, neurosyphilis, B12 deficiency), substance-induced states (alcohol, cannabis, stimulants, hallucinogens, steroids, anticholinergics, dopaminergic drugs), and mood-primary psychosis (psychosis only during mood episodes → F30-F33 with psychotic features, not this block).

`Yes (primary) →` proceed to Step 03. `No →` code the underlying cause; not this block.

03 **Does it meet schizophrenia criteria?** For ICD-10/ICD-11: characteristic psychotic syndrome present most of the time for at least one month, with the required combination of positive, negative, disorganisation, and passivity features, plus exclusion of mood primacy. For DSM-5: two or more Criterion A symptoms (with at least one delusion, hallucination, or disorganised speech), six months total disturbance with one month active phase, functional decline, exclusion criteria.

`Yes →` F20 / 6A20 Schizophrenia / DSM-5 Schizophrenia. `No →` proceed to Step 04.

04 **Is it a focal persistent delusional pattern?** One delusion or related delusions dominates; no formal thought disorder; no persistent non-content-congruent hallucinations; no negative symptoms; no schizophrenia syndrome; duration meets threshold (≥3 months ICD, ≥1 month DSM); functioning preserved outside delusional theme.

`Yes →` F22 / 6A24 Delusional disorder / DSM-5 Delusional disorder. Specify subtype. `No →` proceed to Step 05.

05 **Do you have enough information to specify what the pattern is and why it does not fit the named disorders?**

`Yes →` F28 / 6A2Y Other specified primary psychotic disorder / DSM-5 Other specified. Provide the specifier. `No →` F29 / 6A2Z Unspecified primary psychotic disorder / DSM-5 Unspecified. Write the reassessment date in the chart.

> CROSS-CHECK BEFORE COMMITTING
>
> Before signing the code, ask: Is the duration consistent with the chosen code? Is the functioning consistent? Is the mood timeline excluded? Is the substance timeline excluded? Is the family history a useful prior (early onset and family loading for F20; late onset and sensory deprivation for F22)? Is the cultural content of the delusion within the range of the patient's reference group (the ICD-11 caution against over-diagnosis of culturally normative idioms applies here)?

10 / DOCUMENTATION

What to write in the chart

The chart is the durable artefact of the diagnostic decision. The code without the supporting narrative is a billing entry, not a clinical record. These four templates cover the documentation requirements for each code in a single-page chart entry.

10.1 If coding F20 / 6A20 / DSM-5 Schizophrenia

Timeline: onset, prodrome, active-phase start date, total duration to date.
Positive symptoms: delusions (type, fixity, content), hallucinations (modality, frequency, content), formal thought disorder (examples observed).
Negative symptoms: blunted affect, avolition, alogia, anhedonia, asociality.
Disorganisation / catatonia: examples, severity, duration.
Functioning: baseline versus current (work, education, self-care, relationships).
Mood symptoms: any episodes meeting criteria? proportion of time relative to psychotic period?
Exclusions: substance history with timeline; tox where feasible; medical and neurological causes considered; relevant labs and imaging if indicated.
Course specifier: first episode, multiple episodes, continuous; currently symptomatic, partial remission, full remission.
Treatment plan: SGA monotherapy at minimum effective dose; review at 4-6 weeks; LAI consideration if adherence-relevant.

10.2 If coding F22 / 6A24 / DSM-5 Delusional disorder

Delusion: exact content, conviction, fixity, duration, triggers, fluctuation.
Subtype: persecutory / grandiose / jealous / somatic / erotomanic / mixed.
Hallucinations: absent or content-congruent only (specify modality and tie to delusional theme).
Phenomenology negatives: no formal thought disorder, no negative symptoms, no persistent non-congruent hallucinations, no schizophrenia syndrome.
Functioning: preserved or impaired only within the delusional theme; document evidence (work, household, social, self-care).
Risk: forensic (jealous and erotomanic types), litigious behaviour (persecutory), self-neglect or harm to others.
Sensory and cognitive screen: hearing, vision, MMSE/MoCA in late-onset cases.
Exclusions: organic, substance, mood primacy.
Treatment plan: antipsychotic monotherapy; LAI consideration; psychosocial; family work where folie a deux or relational risk.

10.3 If coding F28 / 6A2Y / DSM-5 Other specified

Specifier (mandatory): name the pattern. Examples: persistent auditory hallucinations without other syndrome elements; chronic hallucinatory psychosis; sensitive Beziehungswahn; monosymptomatic state at six weeks duration; atypical mixed psychotic features with delusions and partial mood overlap below schizoaffective threshold; culture-related primary psychosis not meeting F20/F22/F23/F25 criteria.
Why not F20: which schizophrenia criterion is not met.
Why not F22: single-delusion focality not present, or schizophrenia features present.
Why not F23: duration exceeds the acute and transient threshold, or onset was not sudden.
Why not F25: mood syndrome does not meet schizoaffective threshold.
Plan for longitudinal clarification: collateral, follow-up, reassessment date.

10.4 If coding F29 / 6A2Z / DSM-5 Unspecified

> **Statement of uncertainty:** "Provisional diagnosis: F29 / 6A2Z, insufficient information to specify."
> **Immediate differentials:** the named codes being considered (typically F20, F22, F23, F25, F31 with psychotic features, F1x substance-induced).
> **Exclusion work-up in progress:** vitals, neuro exam, CBC, RFT, LFT, electrolytes, glucose, TSH, B12 and folate if indicated, urine toxicology where feasible, pregnancy test when relevant, ECG and imaging when indicated.
> **Reassessment plan:** timepoint, what new information is being sought, code-revision intent.
> **Treatment in the interim:** SGA at low to moderate dose for safety and symptom containment; short course benzodiazepine if severe agitation; document indication.
> **Re-code at:** 1 week (substance and medical exclusions plus clearer phenomenology → move from F29 if possible); 4-6 weeks (response to adequate antipsychotic trial); 3 months (senior review if still F29).

11 / INDIAN FRAME

Practice, paraphrenia, and the cultural lens

Indian psychiatric practice maps onto the four codes with three practice-shaping features. The first is the persistence of paraphrenia as an active clinical idiom alongside its formal disappearance from ICD-11. The second is the cultural shaping of delusional content. The third is the late-onset Roth phenotype, which is over-represented in Indian OPDs because of demographic and social patterns and is the most consistently miscoded presentation in the differential.

Paraphrenia, where it lives now

Kraepelin's 1913 concept of paraphrenia, chronic systematised delusions and hallucinations with preserved personality and affect, no deterioration, survives in Indian textbooks (Vyas and Ahuja) and in clinical discussion as a bedside descriptor.[16] It maps formally to F22.8 (involutional paranoid state, paraphrenia [late]) in ICD-10, and is folded into 6A24 or 6A2Y in ICD-11. The clinical utility is real: paraphrenia as a label captures a recognisable phenotype that often sits uncomfortably in both F20 and F22 without the descriptor. The chart should use the F-code for billing and the descriptive term in the formulation narrative.

Cultural content of delusions

Indian delusional content is culturally patterned. Possession (*bhoot, jinn, pret*), black magic (*jaadu-tona*), tantric harm, sorcery by neighbours, and persecutory beliefs around in-laws (particularly in women) are common content categories. The ICD-11 CDDR explicitly cautions against over-diagnosis of culturally normative idioms.[2] The clinical question is not whether the content is culturally available but whether the conviction, distress, preoccupation, and functional impact exceed the patient's reference group's threshold. A woman who believes her saas has put *jaadu-tona* on her, who continues to function and whose family does not share the belief, is not necessarily delusional; a woman who believes the same thing, has stopped eating, has stopped sleeping, has refused to leave her room for four months, and whose family considers her belief abnormal, is. The reference group, not the content, is the discriminator.

Religious and grandiose content

Identification with deities or being an avatar is a recurring content theme in Indian samples. The differential from culturally sanctioned *bhakti* experiences, possession states in religious contexts, and spiritual emergency uses the same threshold criteria, conviction, distress, preoccupation, functional impact, reference group. Cultural formulation is not a permission to under-diagnose. It is a requirement to assess against the patient's actual community.

The Roth phenotype in Indian OPDs

The Roth late-paraphrenia phenotype, onset after forty-five, often after sixty; female predominance; widowed; sensory impairment (deafness or low vision); social isolation; persecutory or referential content, is over-represented in Indian general adult and geriatric psychiatry OPDs because of the demographic pattern (longer life expectancy in women, widowhood patterns, hearing-aid access gap, social isolation in joint-family transitions). The international consensus retired "late paraphrenia" in 2000 in favour of Late-Onset Schizophrenia and Very-Late-Onset Schizophrenia-Like Psychosis, with the latter responding to lower antipsychotic doses (twenty-five to fifty percent of adult dose) and carrying higher tardive dyskinesia risk.[11] In Indian practice, this phenotype is most commonly coded F20 on first contact, often miscoded, and most usefully formulated as F22 with paraphrenia or VLOSLP as the descriptor.

The MHCA 2017 implications

The Mental Healthcare Act 2017 applies across the four codes when admission, treatment, or capacity questions arise. The Act's emphasis on dignity, least restrictive care, advance directives, nominated representatives, and capacity assessment does not change with the code. The practical difference at the bedside is that an F22 patient with preserved general functioning and a single delusional theme often has preserved capacity for treatment decisions outside the delusional system, and supported admission processes should be calibrated accordingly. The F20 patient with broad functional decline more often requires the supported admission framework. The F29 patient, by definition, has incomplete capacity assessment information; the documented work-up plan should include capacity.

The Indian disability frame

The Rights of Persons with Disabilities Act 2016 and the DEPwD assessment guidelines apply when chronic mental illness disability certification is at issue. Permanent certification requires at least two years duration and residual disability despite appropriate evidence-based treatment.[17] Schizophrenia (F20) is the named disorder for which IDEAS-based certification is best established. Delusional disorder (F22) can support certification if the functional impairment exceeds threshold, but in practice F22 patients with preserved functioning outside the delusional theme often do not meet the IDEAS threshold. F28 and F29 are unlikely to support permanent certification by themselves; they should be revised to a named code before certification is sought.

12 / SPECIAL

The eponymic syndromes in one place

The eponymic delusional syndromes are scattered across the differential. They are listed here as a reference table for viva and bedside use.

Capgras

PHENOMENOLOGY
Familiar person replaced by impostor
CODE LOCATION
F20 in 73% (most common); F22 misidentification subtype; F06 organic causes (TBI, dementia)
PRACTICAL PEARL
Right frontotemporal dysfunction; check for Lewy body disease in late-onset cases; the lede case of this issue is a Capgras presentation

Cotard

PHENOMENOLOGY
Nihilistic delusion of being dead, decaying, organs missing
CODE LOCATION
F32/F33 with psychotic features most common; F20 next; less commonly F22
PRACTICAL PEARL
Strong association with psychotic depression; responds to ECT; do not anchor on F22

Ekbom (delusional infestation)

PHENOMENOLOGY
Belief that one is infested with parasites, insects, or fibres
CODE LOCATION
F22 somatic subtype
PRACTICAL PEARL
Matchbox sign (patient brings specimens); presents to dermatology first; risperidone or olanzapine first line; pimozide historical with ECG monitoring

Othello syndrome (morbid jealousy)

PHENOMENOLOGY
Partner is unfaithful, with surveillance and confrontation
CODE LOCATION
F22 jealous subtype; consider F10 (alcohol) and F02 (frontal pathology) drivers
PRACTICAL PEARL
High homicide risk; alcohol dependence common in Indian forensic samples; assess for cognitive decline and stimulant use

Erotomania (de Clerambault)

PHENOMENOLOGY
Higher-status person is in love with the patient
CODE LOCATION
F22 erotomanic subtype; can occur in F20
PRACTICAL PEARL
Three phases (hope, spite, resentment); forensic risk in spite and resentment phases; stalking risk

Folie a deux

PHENOMENOLOGY
Shared delusion between two persons in close relationship
CODE LOCATION
F24 in ICD-10; folded into F22 / 6A24 in ICD-11; each individual coded
PRACTICAL PEARL
Inducer plus induced; separation often resolves the induced delusion within weeks; assess capacity and risk separately

Paraphrenia (Kraepelin)

PHENOMENOLOGY
Chronic systematised delusions and hallucinations with preserved personality
CODE LOCATION
F22.8 ICD-10; folded into F22 / 6A24 in ICD-11
PRACTICAL PEARL
Bedside descriptor still in active Indian clinical use; chart uses F-code plus descriptor

Late paraphrenia (Roth)

PHENOMENOLOGY
Onset after 45, paranoid delusions with or without auditory hallucinations, preserved personality
CODE LOCATION
Retired as a term in 2000; now classified as Late-Onset Schizophrenia (40-60) or VLOSLP (over 60)
PRACTICAL PEARL
Female predominance; sensory deprivation and social isolation as risks; responds to lower antipsychotic doses

The lede case, resolved

The 54-year-old woman with the nine-month belief that her husband has been replaced by an impostor, no thought disorder, no negative symptoms, reactive affect, preserved self-care and cognition. The most likely code is **F22 / 6A24 / DSM-5 Delusional disorder**, mixed or persecutory subtype, with Capgras as the phenomenological descriptor. The clinical work is to exclude organic causes (right frontotemporal pathology, Lewy body disease, post-vascular event), confirm the absence of broader schizophrenia syndrome on extended examination and collateral history, document the duration (nine months exceeds both ICD and DSM thresholds), and initiate antipsychotic treatment with risperidone or olanzapine at standard adult doses with a low threshold for LAI conversion given the encapsulated nature of the belief and the typical poor insight pattern of F22. Follow-up at four to six weeks for response, and at six months for diagnostic stability review. The probability of conversion to F20 over the next four years is approximately one in three. [1]

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Educational note. This clinical-reasoning essay is for clinicians and students. It is educational, not treatment advice for any individual. Care decisions belong with the treating clinician. At Weave, care is led by Dr. Niharika Reddy, Consultant Psychiatrist.

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Colophon. Aporia is a serialised clinical reasoning publication by Dr. Wilfred D'souza, third-year MD Psychiatry resident at KMCRI, Hubli. Issue 03 was written in May 2026. The seed material was a Notion-exported diagnostic brief on F20 vs F28 vs F29 (the brief flagged the F22 ambiguity at the top). The brief was extended to a four-way differential covering F20, F22, F28 and F29. F22 deep research was synthesised across the 2022 to 2024 literature on delusional disorder, with anchor citations to the Hong Kong first-episode cohort, the Munro foundational work, and the Lahteenvuo Swedish national cohort. The Indian frame draws on Grover and Avasthi's 2017 IPS CPG for delusional disorder, the 2024 DEPwD disability assessment guidelines, and the 2026 IPS CPG for schizophrenia. The eponymic syndromes are referenced to the systematic reviews where available. Set in Switzer, JetBrains Mono and Newsreader. Comments to wilfred@weave.clinic.