

Differential Diagnosis

Other medical conditions. A variety of medical disorders can manifest with psychotic symptoms of short duration. Psychotic disorder due to another medical condition or a delirium is diagnosed when there is evidence from the history, physical examination, or laboratory tests that the delusions or hallucinations are the direct physiological consequence of a specific medical condition (e.g., Cushing's syndrome, brain tumor) (see "Psychotic Disorder Due to Another Medical Condition" later in this chapter).

Substance-related disorders. Substance/medication-induced psychotic disorder, substance-induced delirium, and substance intoxication are distinguished from brief psychotic disorder by the fact that a substance (e.g., a drug of abuse, a medication, exposure to a toxin) is judged to be etiologically related to the psychotic symptoms (see "Substance/Medication-Induced Psychotic Disorder" later in this chapter). Laboratory tests, such as a urine drug screen or a blood alcohol level, may be helpful in making this determination, as may a careful history of substance use with attention to temporal relationships between substance intake and onset of the symptoms and to the nature of the substance being used.

Depressive and bipolar disorders. The diagnosis of brief psychotic disorder cannot be made if the psychotic symptoms are better explained by a mood episode (i.e., the psychotic symptoms occur exclusively during a full major depressive, manic, or mixed episode).

Other psychotic disorders. If the psychotic symptoms persist for 1 month or longer, the diagnosis is either schizoaffective disorder, delusional disorder, depressive disorder with psychotic features, bipolar disorder with psychotic features, or other specified or unspecified schizophrenia spectrum and other psychotic disorder, depending on the other symptoms in the presentation. The differential diagnosis between brief psychotic disorder and schizoaffective disorder is difficult when the psychotic symptoms have remitted before 1 month in response to successful treatment with medication. Careful attention should be given to the possibility that a recurrent disorder (e.g., bipolar disorder, recurrent acute exacerbations of schizophrenia) may be responsible for any recurring psychotic episodes.

Malingering and factitious disorders. An episode of factitious disorder, with predominantly psychological signs and symptoms, may have the appearance of brief psychotic disorder, but in such cases there is evidence that the symptoms are intentionally produced. When malingering involves apparently psychotic symptoms, there is usually evidence that the illness is being feigned for an understandable goal.

Personality disorders. In certain individuals with personality disorders, psychosocial stressors may precipitate brief periods of psychotic symptoms. These symptoms are usually transient and do not warrant a separate diagnosis. If psychotic symptoms persist for at least 1 day, an additional diagnosis of brief psychotic disorder may be appropriate.

Schizoaffective Disorder

Diagnostic Criteria

295.40 (F20.81)

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

- B. An episode of the disorder lasts at least 1 month but less than 6 months. When the diagnosis must be made without waiting for recovery, it should be qualified as “provisional.”
- C. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify if:

With good prognostic features: This specifier requires the presence of at least two of the following features: onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning; confusion or perplexity; good premorbid social and occupational functioning; and absence of blunted or flat affect.

Without good prognostic features: This specifier is applied if two or more of the above features have not been present.

Specify if:

With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition).

Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizophreniform disorder to indicate the presence of the comorbid catatonia.

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)

Note: Diagnosis of schizophreniform disorder can be made without using this severity specifier.

Note: For additional information on Associated Features Supporting Diagnosis, Development and Course (age-related factors), Culture-Related Diagnostic Issues, Gender-Related Diagnostic Issues, Differential Diagnosis, and Comorbidity, see the corresponding sections in schizophrenia.

Diagnostic Features

The characteristic symptoms of schizophreniform disorder are identical to those of schizophrenia (Criterion A). Schizophreniform disorder is distinguished by its difference in duration: the total duration of the illness, including prodromal, active, and residual phases, is at least 1 month but less than 6 months (Criterion B). The duration requirement for schizophreniform disorder is intermediate between that for brief psychotic disorder, which lasts more than 1 day and remits by 1 month, and schizophrenia, which lasts for at least 6 months. The diagnosis of schizophreniform disorder is made under two conditions. 1) when an episode of illness lasts between 1 and 6 months and the individual has already recovered, and 2) when an individual is symptomatic for less than the 6 months’ duration required for the diagnosis of schizophrenia but has not yet recovered. In this case, the diagnosis should be noted as “schizophreniform disorder (provisional)” because it is uncertain if the individual will recover from the disturbance within the 6-month period. If the disturbance persists beyond 6 months, the diagnosis should be changed to schizophrenia.

Another distinguishing feature of schizopreniform disorder is the lack of a criterion requiring impaired social and occupational functioning. While such impairments may potentially be present, they are not necessary for a diagnosis of schizopreniform disorder.

In addition to the five symptom domain areas identified in the diagnostic criteria, the assessment of cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders.

Associated Features Supporting Diagnosis

As with schizophrenia, currently there are no laboratory or psychometric tests for schizopreniform disorder. There are multiple brain regions where neuroimaging, neuropathological, and neurophysiological research has indicated abnormalities, but none are diagnostic.

Prevalence

Incidence of schizopreniform disorder across sociocultural settings is likely similar to that observed in schizophrenia. In the United States and other developed countries, the incidence is low, possibly fivefold less than that of schizophrenia. In developing countries, the incidence may be higher, especially for the specifier "with good prognostic features"; in some of these settings schizopreniform disorder may be as common as schizophrenia.

Development and Course

The development of schizopreniform disorder is similar to that of schizophrenia. About one-third of individuals with an initial diagnosis of schizopreniform disorder (provisional) recover within the 6-month period and schizopreniform disorder is their final diagnosis. The majority of the remaining two-thirds of individuals will eventually receive a diagnosis of schizophrenia or schizoaffective disorder.

Risk and Prognostic Factors

Genetic and physiological. Relatives of individuals with schizopreniform disorder have an increased risk for schizophrenia.

Functional Consequences of Schizopreniform Disorder

For the majority of individuals with schizopreniform disorder who eventually receive a diagnosis of schizophrenia or schizoaffective disorder, the functional consequences are similar to the consequences of those disorders. Most individuals experience dysfunction in several areas of daily functioning, such as school or work, interpersonal relationships, and self-care. Individuals who recover from schizopreniform disorder have better functional outcomes.

Differential Diagnosis

Other mental disorders and medical conditions. A wide variety of mental and medical conditions can manifest with psychotic symptoms that must be considered in the differential diagnosis of schizopreniform disorder. These include psychotic disorder due to another medical condition or its treatment; delirium or major neurocognitive disorder; substance/medication-induced psychotic disorder or delirium; depressive or bipolar disorder with psychotic features; schizoaffective disorder; other specified or unspecified bipolar and related disorder; depressive or bipolar disorder with catatonic features; schizophre-

nia; brief psychotic disorder; delusional disorder; other specified or unspecified schizophrenia spectrum and other psychotic disorder; schizotypal, schizoid, or paranoid personality disorders; autism spectrum disorder; disorders presenting in childhood with disorganized speech; attention-deficit/hyperactivity disorder; obsessive-compulsive disorder; posttraumatic stress disorder; and traumatic brain injury.

Since the diagnostic criteria for schizoaffective disorder and schizophrenia differ primarily in duration of illness, the discussion of the differential diagnosis of schizophrenia also applies to schizoaffective disorder.

Brief psychotic disorder. Schizoaffective disorder differs in duration from brief psychotic disorder, which has a duration of less than 1 month.

Schizophrenia

Diagnostic Criteria

295.90 (F20.9)

- A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
 1. Delusions.
 2. Hallucinations.
 3. Disorganized speech (e.g., frequent derailment or incoherence).
 4. Grossly disorganized or catatonic behavior.
 5. Negative symptoms (i.e., diminished emotional expression or avolition).
- B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
- C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

Specify if:

The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An *acute episode* is a time period in which the symptom criteria are fulfilled.

First episode, currently in partial remission: *Partial remission* is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

First episode, currently in full remission: *Full remission* is a period of time after a previous episode during which no disorder-specific symptoms are present.

Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

Unspecified

Specify if:

With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition).

Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizophrenia to indicate the presence of the comorbid catatonia.

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)

Note: Diagnosis of schizophrenia can be made without using this severity specifier.

Diagnostic Features

The characteristic symptoms of schizophrenia involve a range of cognitive, behavioral, and emotional dysfunctions, but no single symptom is pathognomonic of the disorder. The diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning. Individuals with the disorder will vary substantially on most features, as schizophrenia is a heterogeneous clinical syndrome.

At least two Criterion A symptoms must be present for a significant portion of time during a 1-month period or longer. At least one of these symptoms must be the clear presence of delusions (Criterion A1), hallucinations (Criterion A2), or disorganized speech (Criterion A3). Grossly disorganized or catatonic behavior (Criterion A4) and negative symptoms (Criterion A5) may also be present. In those situations in which the active-phase symptoms remit within a month in response to treatment, Criterion A is still met if the clinician estimates that they would have persisted in the absence of treatment.

Schizophrenia involves impairment in one or more major areas of functioning (Criterion B). If the disturbance begins in childhood or adolescence, the expected level of function is not attained. Comparing the individual with unaffected siblings may be helpful. The dysfunction persists for a substantial period during the course of the disorder and does not appear to be a direct result of any single feature. Avolition (i.e., reduced drive to pursue goal-directed behavior; Criterion A5) is linked to the social dysfunction described under Criterion B. There is also strong evidence for a relationship between cognitive impairment (see the section “Associated Features Supporting Diagnosis” for this disorder) and functional impairment in individuals with schizophrenia.

Some signs of the disturbance must persist for a continuous period of at least 6 months (Criterion C). Prodromal symptoms often precede the active phase, and residual symptoms may follow it, characterized by mild or subthreshold forms of hallucinations or delusions. Individuals may express a variety of unusual or odd beliefs that are not of delusional proportions (e.g., ideas of reference or magical thinking); they may have unusual perceptual experiences (e.g., sensing the presence of an unseen person); their speech may be generally understandable but vague; and their behavior may be unusual but not grossly disorganized (e.g., mumbling in public). Negative symptoms are common in the prodromal and residual phases and can be severe. Individuals who had been socially active may become withdrawn from previous routines. Such behaviors are often the first sign of a disorder.

Mood symptoms and full mood episodes are common in schizophrenia and may be concurrent with active-phase symptomatology. However, as distinct from a psychotic mood disorder, a schizophrenia diagnosis requires the presence of delusions or hallucinations in the absence of mood episodes. In addition, mood episodes, taken in total, should be present for only a minority of the total duration of the active and residual periods of the illness.

In addition to the five symptom domain areas identified in the diagnostic criteria, the assessment of cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders.

Associated Features Supporting Diagnosis

Individuals with schizophrenia may display inappropriate affect (e.g., laughing in the absence of an appropriate stimulus); a dysphoric mood that can take the form of depression, anxiety, or anger; a disturbed sleep pattern (e.g., daytime sleeping and nighttime activity); and a lack of interest in eating or food refusal. Depersonalization, derealization, and somatic concerns may occur and sometimes reach delusional proportions. Anxiety and phobia are common. Cognitive deficits in schizophrenia are common and are strongly linked to vocational and functional impairments. These deficits can include decrements in declarative memory, working memory, language function, and other executive functions, as well as slower processing speed. Abnormalities in sensory processing and inhibitory capacity, as well as reductions in attention, are also found. Some individuals with schizophrenia show social cognition deficits, including deficits in the ability to infer the intentions of other people (theory of mind), and may attend to and then interpret irrelevant events or stimuli as meaningful, perhaps leading to the generation of explanatory delusions. These impairments frequently persist during symptomatic remission.

Some individuals with psychosis may lack insight or awareness of their disorder (i.e., anosognosia). This lack of "insight" includes unawareness of symptoms of schizophrenia and may be present throughout the entire course of the illness. Unawareness of illness is typically a symptom of schizophrenia itself rather than a coping strategy. It is comparable to the lack of awareness of neurological deficits following brain damage, termed *anosognosia*. This symptom is the most common predictor of non-adherence to treatment, and it predicts higher relapse rates, increased number of involuntary treatments, poorer psychosocial functioning, aggression, and a poorer course of illness.

Hostility and aggression can be associated with schizophrenia, although spontaneous or random assault is uncommon. Aggression is more frequent for younger males and for individuals with a past history of violence, non-adherence with treatment, substance abuse, and impulsivity. It should be noted that the vast majority of persons with schizophrenia are not aggressive and are more frequently victimized than are individuals in the general population.

Currently, there are no radiological, laboratory, or psychometric tests for the disorder. Differences are evident in multiple brain regions between groups of healthy individuals

and persons with schizophrenia, including evidence from neuroimaging, neuropathological, and neurophysiological studies. Differences are also evident in cellular architecture, white matter connectivity, and gray matter volume in a variety of regions such as the prefrontal and temporal cortices. Reduced overall brain volume has been observed, as well as increased brain volume reduction with age. Brain volume reductions with age are more pronounced in individuals with schizophrenia than in healthy individuals. Finally, individuals with schizophrenia appear to differ from individuals without the disorder in eye-tracking and electrophysiological indices.

Neurological soft signs common in individuals with schizophrenia include impairments in motor coordination, sensory integration, and motor sequencing of complex movements; left-right confusion; and disinhibition of associated movements. In addition, minor physical anomalies of the face and limbs may occur.

Prevalence

The lifetime prevalence of schizophrenia appears to be approximately 0.3%–0.7%, although there is reported variation by race/ethnicity, across countries, and by geographic origin for immigrants and children of immigrants. The sex ratio differs across samples and populations: for example, an emphasis on negative symptoms and longer duration of disorder (associated with poorer outcome) shows higher incidence rates for males, whereas definitions allowing for the inclusion of more mood symptoms and brief presentations (associated with better outcome) show equivalent risks for both sexes.

Development and Course

The psychotic features of schizophrenia typically emerge between the late teens and the mid-30s; onset prior to adolescence is rare. The peak age at onset for the first psychotic episode is in the early- to mid-20s for males and in the late-20s for females. The onset may be abrupt or insidious, but the majority of individuals manifest a slow and gradual development of a variety of clinically significant signs and symptoms. Half of these individuals complain of depressive symptoms. Earlier age at onset has traditionally been seen as a predictor of worse prognosis. However, the effect of age at onset is likely related to gender, with males having worse premorbid adjustment, lower educational achievement, more prominent negative symptoms and cognitive impairment, and in general a worse outcome. Impaired cognition is common, and alterations in cognition are present during development and precede the emergence of psychosis, taking the form of stable cognitive impairments during adulthood. Cognitive impairments may persist when other symptoms are in remission and contribute to the disability of the disease.

The predictors of course and outcome are largely unexplained, and course and outcome may not be reliably predicted. The course appears to be favorable in about 20% of those with schizophrenia, and a small number of individuals are reported to recover completely. However, most individuals with schizophrenia still require formal or informal daily living supports, and many remain chronically ill, with exacerbations and remissions of active symptoms, while others have a course of progressive deterioration.

Psychotic symptoms tend to diminish over the life course, perhaps in association with normal age-related declines in dopamine activity. Negative symptoms are more closely related to prognosis than are positive symptoms and tend to be the most persistent. Furthermore, cognitive deficits associated with the illness may not improve over the course of the illness.

The essential features of schizophrenia are the same in childhood, but it is more difficult to make the diagnosis. In children, delusions and hallucinations may be less elaborate than in adults, and visual hallucinations are more common and should be distinguished from normal fantasy play. Disorganized speech occurs in many disorders with childhood onset (e.g., autism spectrum disorder), as does disorganized behavior (e.g., attention-deficit/

hyperactivity disorder). These symptoms should not be attributed to schizophrenia without due consideration of the more common disorders of childhood. Childhood-onset cases tend to resemble poor-outcome adult cases, with gradual onset and prominent negative symptoms. Children who later receive the diagnosis of schizophrenia are more likely to have experienced nonspecific emotional-behavioral disturbances and psychopathology, intellectual and language alterations, and subtle motor delays.

Late-onset cases (i.e., onset after age 40 years) are overrepresented by females, who may have married. Often, the course is characterized by a predominance of psychotic symptoms with preservation of affect and social functioning. Such late-onset cases can still meet the diagnostic criteria for schizophrenia, but it is not yet clear whether this is the same condition as schizophrenia diagnosed prior to mid-life (e.g., prior to age 55 years).

Risk and Prognostic Factors

Environmental. Season of birth has been linked to the incidence of schizophrenia, including late winter/early spring in some locations and summer for the deficit form of the disease. The incidence of schizophrenia and related disorders is higher for children growing up in an urban environment and for some minority ethnic groups.

Genetic and physiological. There is a strong contribution for genetic factors in determining risk for schizophrenia, although most individuals who have been diagnosed with schizophrenia have no family history of psychosis. Liability is conferred by a spectrum of risk alleles, common and rare, with each allele contributing only a small fraction to the total population variance. The risk alleles identified to date are also associated with other mental disorders, including bipolar disorder, depression, and autism spectrum disorder.

Pregnancy and birth complications with hypoxia and greater paternal age are associated with a higher risk of schizophrenia for the developing fetus. In addition, other prenatal and perinatal adversities, including stress, infection, malnutrition, maternal diabetes, and other medical conditions, have been linked with schizophrenia. However, the vast majority of offspring with these risk factors do not develop schizophrenia.

Culture-Related Diagnostic Issues

Cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and socioeconomic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content (e.g., hearing God's voice) are a normal part of religious experience. In addition, the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures. The assessment of affect requires sensitivity to differences in styles of emotional expression, eye contact, and body language, which vary across cultures. If the assessment is conducted in a language that is different from the individual's primary language, care must be taken to ensure that alogia is not related to linguistic barriers. In certain cultures, distress may take the form of hallucinations or pseudo-hallucinations and overvalued ideas that may present clinically similar to true psychosis but are normative to the patient's subgroup.

Gender-Related Diagnostic Issues

A number of features distinguish the clinical expression of schizophrenia in females and males. The general incidence of schizophrenia tends to be slightly lower in females, particularly among treated cases. The age at onset is later in females, with a second mid-life peak as described earlier (see the section "Development and Course" for this disorder). Symptoms tend to be more affect-laden among females, and there are more psychotic symptoms, as well as a greater propensity for psychotic symptoms to worsen in later life.

Other symptom differences include less frequent negative symptoms and disorganization. Finally, social functioning tends to remain better preserved in females. There are, however, frequent exceptions to these general caveats.

Suicide Risk

Approximately 5%–6% of individuals with schizophrenia die by suicide, about 20% attempt suicide on one or more occasions, and many more have significant suicidal ideation. Suicidal behavior is sometimes in response to command hallucinations to harm oneself or others. Suicide risk remains high over the whole lifespan for males and females, although it may be especially high for younger males with comorbid substance use. Other risk factors include having depressive symptoms or feelings of hopelessness and being unemployed, and the risk is higher, also, in the period after a psychotic episode or hospital discharge.

Functional Consequences of Schizophrenia

Schizophrenia is associated with significant social and occupational dysfunction. Making educational progress and maintaining employment are frequently impaired by avolition or other disorder manifestations, even when the cognitive skills are sufficient for the tasks at hand. Most individuals are employed at a lower level than their parents, and most, particularly men, do not marry or have limited social contacts outside of their family.

Differential Diagnosis

Major depressive or bipolar disorder with psychotic or catatonic features. The distinction between schizophrenia and major depressive or bipolar disorder with psychotic features or with catatonia depends on the temporal relationship between the mood disturbance and the psychosis, and on the severity of the depressive or manic symptoms. If delusions or hallucinations occur exclusively during a major depressive or manic episode, the diagnosis is depressive or bipolar disorder with psychotic features.

Schizoaffective disorder. A diagnosis of schizoaffective disorder requires that a major depressive or manic episode occur concurrently with the active-phase symptoms and that the mood symptoms be present for a majority of the total duration of the active periods.

Schizophreniform disorder and brief psychotic disorder. These disorders are of shorter duration than schizophrenia as specified in Criterion C, which requires 6 months of symptoms. In schizophreniform disorder, the disturbance is present less than 6 months, and in brief psychotic disorder, symptoms are present at least 1 day but less than 1 month.

Delusional disorder. Delusional disorder can be distinguished from schizophrenia by the absence of the other symptoms characteristic of schizophrenia (e.g., delusions, prominent auditory or visual hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms).

Schizotypal personality disorder. Schizotypal personality disorder may be distinguished from schizophrenia by subthreshold symptoms that are associated with persistent personality features.

Obsessive-compulsive disorder and body dysmorphic disorder. Individuals with obsessive-compulsive disorder and body dysmorphic disorder may present with poor or absent insight, and the preoccupations may reach delusional proportions. But these disorders are distinguished from schizophrenia by their prominent obsessions, compulsions, preoccupations with appearance or body odor, hoarding, or body-focused repetitive behaviors.

Posttraumatic stress disorder. Posttraumatic stress disorder may include flashbacks that have a hallucinatory quality, and hypervigilance may reach paranoid proportions. But a tra-

matic event and characteristic symptom features relating to reliving or reacting to the event are required to make the diagnosis.

Autism spectrum disorder or communication disorders. These disorders may also have symptoms resembling a psychotic episode but are distinguished by their respective deficits in social interaction with repetitive and restricted behaviors and other cognitive and communication deficits. An individual with autism spectrum disorder or communication disorder must have symptoms that meet full criteria for schizophrenia, with prominent hallucinations or delusions for at least 1 month, in order to be diagnosed with schizophrenia as a comorbid condition.

Other mental disorders associated with a psychotic episode. The diagnosis of schizophrenia is made only when the psychotic episode is persistent and not attributable to the physiological effects of a substance or another medical condition. Individuals with a delirium or major or minor neurocognitive disorder may present with psychotic symptoms, but these would have a temporal relationship to the onset of cognitive changes consistent with those disorders. Individuals with substance/medication-induced psychotic disorder may present with symptoms characteristic of Criterion A for schizophrenia, but the substance/medication-induced psychotic disorder can usually be distinguished by the chronological relationship of substance use to the onset and remission of the psychosis in the absence of substance use.

Comorbidity

Rates of comorbidity with substance-related disorders are high in schizophrenia. Over half of individuals with schizophrenia have tobacco use disorder and smoke cigarettes regularly. Comorbidity with anxiety disorders is increasingly recognized in schizophrenia. Rates of obsessive-compulsive disorder and panic disorder are elevated in individuals with schizophrenia compared with the general population. Schizotypal or paranoid personality disorder may sometimes precede the onset of schizophrenia.

Life expectancy is reduced in individuals with schizophrenia because of associated medical conditions. Weight gain, diabetes, metabolic syndrome, and cardiovascular and pulmonary disease are more common in schizophrenia than in the general population. Poor engagement in health maintenance behaviors (e.g., cancer screening, exercise) increases the risk of chronic disease, but other disorder factors, including medications, lifestyle, cigarette smoking, and diet, may also play a role. A shared vulnerability for psychosis and medical disorders may explain some of the medical comorbidity of schizophrenia.

Schizoaffective Disorder

Diagnostic Criteria

- A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.
Note: The major depressive episode must include Criterion A1: Depressed mood.
- B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.
- C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.
- D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify whether:

295.70 (F25.0) Bipolar type: This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur.

295.70 (F25.1) Depressive type: This subtype applies if only major depressive episodes are part of the presentation.

Specify if:

With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition).

Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizoaffective disorder to indicate the presence of the comorbid catatonia.

Specify if:

The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An *acute episode* is a time period in which the symptom criteria are fulfilled.

First episode, currently in partial remission: *Partial remission* is a time period during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

First episode, currently in full remission: *Full remission* is a period of time after a previous episode during which no disorder-specific symptoms are present.

Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

Unspecified

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)

Note: Diagnosis of schizoaffective disorder can be made without using this severity specifier.

Note: For additional information on Development and Course (age-related factors), Risk and Prognostic Factors (environmental risk factors), Culture-Related Diagnostic Issues, and Gender-Related Diagnostic Issues, see the corresponding sections in schizophrenia, bipolar I and II disorders, and major depressive disorder in their respective chapters.

Diagnostic Features

The diagnosis of schizoaffective disorder is based on the assessment of an uninterrupted period of illness during which the individual continues to display active or residual symptoms of psychotic illness. The diagnosis is usually, but not necessarily, made during the period of psychotic illness. At some time during the period, Criterion A for schizophrenia

has to be met. Criteria B (social dysfunction) and F (exclusion of autism spectrum disorder or other communication disorder of childhood onset) for schizophrenia do not have to be met. In addition to meeting Criterion A for schizophrenia, there is a major mood episode (major depressive or manic) (Criterion A for schizoaffective disorder). Because loss of interest or pleasure is common in schizophrenia, to meet Criterion A for schizoaffective disorder, the major depressive episode must include pervasive depressed mood (i.e., the presence of markedly diminished interest or pleasure is not sufficient). Episodes of depression or mania are present for the majority of the total duration of the illness (i.e., after Criterion A has been met) (Criterion C for schizoaffective disorder). To separate schizoaffective disorder from a depressive or bipolar disorder with psychotic features, delusions or hallucinations must be present for at least 2 weeks in the absence of a major mood episode (depressive or manic) at some point during the lifetime duration of the illness (Criterion B for schizoaffective disorder). The symptoms must not be attributable to the effects of a substance or another medical condition (Criterion D for schizoaffective disorder).

Criterion C for schizoaffective disorder specifies that mood symptoms meeting criteria for a major mood episode must be present for the majority of the total duration of the active and residual portion of the illness. Criterion C requires the assessment of mood symptoms for the entire course of a psychotic illness, which differs from the criterion in DSM-IV, which required only an assessment of the current period of illness. If the mood symptoms are present for only a relatively brief period, the diagnosis is schizophrenia, not schizoaffective disorder. When deciding whether an individual's presentation meets Criterion C, the clinician should review the total duration of psychotic illness (i.e., both active and residual symptoms) and determine when significant mood symptoms (untreated or in need of treatment with antidepressant and/or mood-stabilizing medication) accompanied the psychotic symptoms. This determination requires sufficient historical information and clinical judgment. For example, an individual with a 4-year history of active and residual symptoms of schizophrenia develops depressive and manic episodes that, taken together, do not occupy more than 1 year during the 4-year history of psychotic illness. This presentation would not meet Criterion C.

In addition to the five symptom domain areas identified in the diagnostic criteria, the assessment of cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders.

Associated Features Supporting Diagnosis

Occupational functioning is frequently impaired, but this is not a defining criterion (in contrast to schizophrenia). Restricted social contact and difficulties with self-care are associated with schizoaffective disorder, but negative symptoms may be less severe and less persistent than those seen in schizophrenia. Anosognosia (i.e., poor insight) is also common in schizoaffective disorder, but the deficits in insight may be less severe and pervasive than those in schizophrenia. Individuals with schizoaffective disorder may be at increased risk for later developing episodes of major depressive disorder or bipolar disorder if mood symptoms continue following the remission of symptoms meeting Criterion A for schizophrenia. There may be associated alcohol and other substance-related disorders.

There are no tests or biological measures that can assist in making the diagnosis of schizoaffective disorder. Whether schizoaffective disorder differs from schizophrenia with regard to associated features such as structural or functional brain abnormalities, cognitive deficits, or genetic risk factors is not clear.

Prevalence

Schizoaffective disorder appears to be about one-third as common as schizophrenia. Lifetime prevalence of schizoaffective disorder is estimated to be 0.3%. The incidence of

schizoaffective disorder is higher in females than in males, mainly due to an increased incidence of the depressive type among females.

Development and Course

The typical age at onset of schizoaffective disorder is early adulthood, although onset can occur anywhere from adolescence to late in life. A significant number of individuals diagnosed with another psychotic illness initially will receive the diagnosis schizoaffective disorder later when the pattern of mood episodes has become more apparent. With the current diagnostic Criterion C, it is expected that the diagnosis for some individuals will convert from schizoaffective disorder to another disorder as mood symptoms become less prominent. The prognosis for schizoaffective disorder is somewhat better than the prognosis for schizophrenia but worse than the prognosis for mood disorders.

Schizoaffective disorder may occur in a variety of temporal patterns. The following is a typical pattern: An individual may have pronounced auditory hallucinations and persecutory delusions for 2 months before the onset of a prominent major depressive episode. The psychotic symptoms and the full major depressive episode are then present for 3 months. Then, the individual recovers completely from the major depressive episode, but the psychotic symptoms persist for another month before they too disappear. During this period of illness, the individual's symptoms concurrently met criteria for a major depressive episode and Criterion A for schizophrenia, and during this same period of illness, auditory hallucinations and delusions were present both before and after the depressive phase. The total period of illness lasted for about 6 months, with psychotic symptoms alone present during the initial 2 months, both depressive and psychotic symptoms present during the next 3 months, and psychotic symptoms alone present during the last month. In this instance, the duration of the depressive episode was not brief relative to the total duration of the psychotic disturbance, and thus the presentation qualifies for a diagnosis of schizoaffective disorder.

The expression of psychotic symptoms across the lifespan is variable. Depressive or manic symptoms can occur before the onset of psychosis, during acute psychotic episodes, during residual periods, and after cessation of psychosis. For example, an individual might present with prominent mood symptoms during the prodromal stage of schizophrenia. This pattern is not necessarily indicative of schizoaffective disorder, since it is the co-occurrence of psychotic and mood symptoms that is diagnostic. For an individual with symptoms that clearly meet the criteria for schizoaffective disorder but who on further follow-up only presents with residual psychotic symptoms (such as subthreshold psychosis and/or prominent negative symptoms), the diagnosis may be changed to schizophrenia, as the total proportion of psychotic illness compared with mood symptoms becomes more prominent. Schizoaffective disorder, bipolar type, may be more common in young adults, whereas schizoaffective disorder, depressive type, may be more common in older adults.

Risk and Prognostic Factors

Genetic and physiological. Among individuals with schizophrenia, there may be an increased risk for schizoaffective disorder in first-degree relatives. The risk for schizoaffective disorder may be increased among individuals who have a first-degree relative with schizophrenia, bipolar disorder, or schizoaffective disorder.

Culture-Related Diagnostic Issues

Cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and economic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another. There is also some evidence in the literature for the overdiagnosis of schizophrenia com-

pared with schizoaffective disorder in African American and Hispanic populations, so care must be taken to ensure a culturally appropriate evaluation that includes both psychotic and affective symptoms.

Suicide Risk

The lifetime risk of suicide for schizophrenia and schizoaffective disorder is 5%, and the presence of depressive symptoms is correlated with a higher risk for suicide. There is evidence that suicide rates are higher in North American populations than in European, Eastern European, South American, and Indian populations of individuals with schizophrenia or schizoaffective disorder.

Functional Consequences of Schizoaffective Disorder

Schizoaffective disorder is associated with social and occupational dysfunction, but dysfunction is not a diagnostic criterion (as it is for schizophrenia), and there is substantial variability between individuals diagnosed with schizoaffective disorder.

Differential Diagnosis

Other mental disorders and medical conditions. A wide variety of psychiatric and medical conditions can manifest with psychotic and mood symptoms that must be considered in the differential diagnosis of schizoaffective disorder. These include psychotic disorder due to another medical condition; delirium; major neurocognitive disorder; substance/medication-induced psychotic disorder or neurocognitive disorder; bipolar disorders with psychotic features; major depressive disorder with psychotic features; depressive or bipolar disorders with catatonic features; schizotypal, schizoid, or paranoid personality disorder; brief psychotic disorder; schizophreniform disorder; schizophrenia; delusional disorder; and other specified and unspecified schizophrenia spectrum and other psychotic disorders. Medical conditions and substance use can present with a combination of psychotic and mood symptoms, and thus psychotic disorder due to another medical condition needs to be excluded. Distinguishing schizoaffective disorder from schizophrenia and from depressive and bipolar disorders with psychotic features is often difficult. Criterion C is designed to separate schizoaffective disorder from schizophrenia, and Criterion B is designed to distinguish schizoaffective disorder from a depressive or bipolar disorder with psychotic features. More specifically, schizoaffective disorder can be distinguished from a depressive or bipolar disorder with psychotic features due to the presence of prominent delusions and/or hallucinations for at least 2 weeks in the absence of a major mood episode. In contrast, in depressive or bipolar disorders with psychotic features, the psychotic features primarily occur during the mood episode(s). Because the relative proportion of mood to psychotic symptoms may change over time, the appropriate diagnosis may change from and to schizoaffective disorder (e.g., a diagnosis of schizoaffective disorder for a severe and prominent major depressive episode lasting 3 months during the first 6 months of a persistent psychotic illness would be changed to schizophrenia if active psychotic or prominent residual symptoms persist over several years without a recurrence of another mood episode).

Psychotic disorder due to another medical condition. Other medical conditions and substance use can manifest with a combination of psychotic and mood symptoms, and thus psychotic disorder due to another medical condition needs to be excluded.

Schizophrenia, bipolar, and depressive disorders. Distinguishing schizoaffective disorder from schizophrenia and from depressive and bipolar disorders with psychotic features is often difficult. Criterion C is designed to separate schizoaffective disorder from schizophrenia, and Criterion B is designed to distinguish schizoaffective disorder from a

depressive or bipolar disorder with psychotic features. More specifically, schizoaffective disorder can be distinguished from a depressive or bipolar disorder with psychotic features based on the presence of prominent delusions and/or hallucinations for at least 2 weeks in the absence of a major mood episode. In contrast, in depressive or bipolar disorder with psychotic features, the psychotic features primarily occur during the mood episode(s). Because the relative proportion of mood to psychotic symptoms may change over time, the appropriate diagnosis may change from and to schizoaffective disorder. (For example, a diagnosis of schizoaffective disorder for a severe and prominent major depressive episode lasting 3 months during the first 6 months of a chronic psychotic illness would be changed to schizophrenia if active psychotic or prominent residual symptoms persist over several years without a recurrence of another mood episode.)

Comorbidity

Many individuals diagnosed with schizoaffective disorder are also diagnosed with other mental disorders, especially substance use disorders and anxiety disorders. Similarly, the incidence of medical conditions is increased above base rate for the general population and leads to decreased life expectancy.

Substance/Medication-Induced Psychotic Disorder

Diagnostic Criteria

- A. Presence of one or both of the following symptoms:
 - 1. Delusions.
 - 2. Hallucinations.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 - 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by a psychotic disorder that is not substance/medication-induced. Such evidence of an independent psychotic disorder could include the following:

The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence of an independent non-substance/medication-induced psychotic disorder (e.g., a history of recurrent non-substance/medication-related episodes).

- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced psychotic disorders are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. If a mild substance use disorder is comorbid with the substance-induced psychotic disorder, the 4th position character is “1,” and the clinician should record “mild [substance] use disorder” before the substance-induced psychotic disorder (e.g., “mild cocaine use disorder with cocaine-induced psychotic disorder”). If a moderate or severe substance use disorder is comorbid with the substance-induced psychotic disorder, the 4th position character is “2,” and the clinician should record “moderate [substance] use disorder” or “severe [substance] use disorder,” depending on the severity of the comorbid substance use disorder. If there is no comorbid substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is “9,” and the clinician should record only the substance-induced psychotic disorder.

	ICD-9-CM	ICD-10-CM		
		With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Alcohol	291.9	F10.159	F10.259	F10.959
Cannabis	292.9	F12.159	F12.259	F12.959
Phencyclidine	292.9	F16.159	F16.259	F16.959
Other hallucinogen	292.9	F16.159	F16.259	F16.959
Inhalant	292.9	F18.159	F18.259	F18.959
Sedative, hypnotic, or anxiolytic	292.9	F13.159	F13.259	F13.959
Amphetamine (or other stimulant)	292.9	F15.159	F15.259	F15.959
Cocaine	292.9	F14.159	F14.259	F14.959
Other (or unknown) substance	292.9	F19.159	F19.259	F19.959

Specify if (see Table 1 in the chapter “Substance-Related and Addictive Disorders” for diagnoses associated with substance class):

With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.

With onset during withdrawal: If the criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)

Note: Diagnosis of substance/medication-induced psychotic disorder can be made without using this severity specifier.

Recording Procedures

ICD-9-CM. The name of the substance/medication-induced psychotic disorder begins with the specific substance (e.g., cocaine, dexamethasone) that is presumed to be causing the delusions or hallucinations. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class. For substances that do not fit into any of the classes (e.g., dexamethasone), the code for “other substance” should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category “unknown substance” should be used.

The name of the disorder is followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal). Unlike the recording procedures for ICD-10-CM, which combine the substance-induced disorder and substance use disorder into a single code, for ICD-9-CM a separate diagnostic code is given for the substance use disorder. For example, in the case of delusions occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is 292.9 cocaine-induced psychotic disorder, with onset during intoxication. An additional diagnosis of 304.20 severe cocaine use disorder is also given. When more than one substance is judged to play a significant role in the development of psychotic symptoms, each should be listed separately (e.g., 292.9 cannabis-induced psychotic disorder with onset during intoxication, with severe cannabis use disorder; 292.9 phencyclidine-induced psychotic disorder, with onset during intoxication, with mild phencyclidine use disorder).

ICD-10-CM. The name of the substance/medication-induced psychotic disorder begins with the specific substance (e.g., cocaine, dexamethasone) that is presumed to be causing the delusions or hallucinations. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes (e.g., dexamethasone), the code for “other substance” with no comorbid substance use should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category “unknown substance” with no comorbid substance use should be used.

When recording the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by the word “with,” followed by the name of the substance-induced psychotic disorder, followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal). For example, in the case of delusions occurring during intoxication in a man with a severe cocaine use disorder, the diagnosis is F14.259 severe cocaine use disorder with cocaine-induced psychotic disorder, with onset during intoxication. A separate diagnosis of the comorbid severe cocaine use disorder is not given. If the substance-induced psychotic disorder occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F16.959 phencyclidine-induced psychotic disorder, with onset during intoxication). When more than one substance is judged to play a significant role in the development of psychotic symptoms, each should be listed separately (e.g., F12.259 severe cannabis use disorder with cannabis-induced psychotic disorder, with onset during intoxication; F16.159 mild phencyclidine use disorder with phencyclidine-induced psychotic disorder, with onset during intoxication).

Diagnostic Features

The essential features of substance/medication-induced psychotic disorder are prominent delusions and/or hallucinations (Criterion A) that are judged to be due to the physiological effects of a substance/medication (i.e., a drug of abuse, a medication, or a toxin exposure) (Criterion B). Hallucinations that the individual realizes are substance/medication-induced are not included here and instead would be diagnosed as substance intoxication

or substance withdrawal with the accompanying specifier “with perceptual disturbances” (applies to alcohol withdrawal; cannabis intoxication; sedative, hypnotic, or anxiolytic withdrawal; and stimulant intoxication).

A substance/medication-induced psychotic disorder is distinguished from a primary psychotic disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of substance use, intoxication, or withdrawal. Substance/medication-induced psychotic disorders arise during or soon after exposure to a medication or after substance intoxication or withdrawal but can persist for weeks, whereas primary psychotic disorders may precede the onset of substance/medication use or may occur during times of sustained abstinence. Once initiated, the psychotic symptoms may continue as long as the substance/medication use continues. Another consideration is the presence of features that are atypical of a primary psychotic disorder (e.g., atypical age at onset or course). For example, the appearance of delusions de novo in a person older than 35 years without a known history of a primary psychotic disorder should suggest the possibility of a substance/medication-induced psychotic disorder. Even a prior history of a primary psychotic disorder does not rule out the possibility of a substance/medication-induced psychotic disorder. In contrast, factors that suggest that the psychotic symptoms are better accounted for by a primary psychotic disorder include persistence of psychotic symptoms for a substantial period of time (i.e., a month or more) after the end of substance intoxication or acute substance withdrawal or after cessation of medication use; or a history of prior recurrent primary psychotic disorders. Other causes of psychotic symptoms must be considered even in an individual with substance intoxication or withdrawal, because substance use problems are not uncommon among individuals with non-substance/medication-induced psychotic disorders.

In addition to the four symptom domain areas identified in the diagnostic criteria, the assessment of cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders.

Associated Features Supporting Diagnosis

Psychotic disorders can occur in association with intoxication with the following classes of substances: alcohol; cannabis; hallucinogens, including phencyclidine and related substances; inhalants; sedatives, hypnotics, and anxiolytics; stimulants (including cocaine); and other (or unknown) substances. Psychotic disorders can occur in association with withdrawal from the following classes of substances: alcohol; sedatives, hypnotics, and anxiolytics; and other (or unknown) substances.

Some of the medications reported to evoke psychotic symptoms include anesthetics and analgesics, anticholinergic agents, anticonvulsants, antihistamines, antihypertensive and cardiovascular medications, antimicrobial medications, antiparkinsonian medications, chemotherapeutic agents (e.g., cyclosporine, procarbazine), corticosteroids, gastrointestinal medications, muscle relaxants, nonsteroidal anti-inflammatory medications, other over-the-counter medications (e.g., phenylephrine, pseudoephedrine), antidepressant medication, and disulfiram. Toxins reported to induce psychotic symptoms include anticholinesterase, organophosphate insecticides, sarin and other nerve gases, carbon monoxide, carbon dioxide, and volatile substances such as fuel or paint.

Prevalence

Prevalence of substance/medication-induced psychotic disorder in the general population is unknown. Between 7% and 25% of individuals presenting with a first episode of psychosis in different settings are reported to have substance/medication-induced psychotic disorder.

Development and Course

The initiation of the disorder may vary considerably with the substance. For example, smoking a high dose of cocaine may produce psychosis within minutes, whereas days or weeks of high-dose alcohol or sedative use may be required to produce psychosis. Alcohol-induced psychotic disorder, with hallucinations, usually occurs only after prolonged, heavy ingestion of alcohol in individuals who have moderate to severe alcohol use disorder, and the hallucinations are generally auditory in nature.

Psychotic disorders induced by amphetamine and cocaine share similar clinical features. Persecutory delusions may rapidly develop shortly after use of amphetamine or a similarly acting sympathomimetic. The hallucination of bugs or vermin crawling in or under the skin (formication) can lead to scratching and extensive skin excoriations. Cannabis-induced psychotic disorder may develop shortly after high-dose cannabis use and usually involves persecutory delusions, marked anxiety, emotional lability, and depersonalization. The disorder usually remits within a day but in some cases may persist for a few days.

Substance/medication-induced psychotic disorder may at times persist when the offending agent is removed, such that it may be difficult initially to distinguish it from an independent psychotic disorder. Agents such as amphetamines, phencyclidine, and cocaine have been reported to evoke temporary psychotic states that can sometimes persist for weeks or longer despite removal of the agent and treatment with neuroleptic medication. In later life, polypharmacy for medical conditions and exposure to medications for parkinsonism, cardiovascular disease, and other medical disorders may be associated with a greater likelihood of psychosis induced by prescription medications as opposed to substances of abuse.

Diagnostic Markers

With substances for which relevant blood levels are available (e.g., blood alcohol level, other quantifiable blood levels such as digoxin), the presence of a level consistent with toxicity may increase diagnostic certainty.

Functional Consequences of Substance/Medication-Induced Psychotic Disorder

Substance/medication-induced psychotic disorder is typically severely disabling and consequently is observed most frequently in emergency rooms, as individuals are often brought to the acute-care setting when it occurs. However, the disability is typically self-limited and resolves upon removal of the offending agent.

Differential Diagnosis

Substance intoxication or substance withdrawal. Individuals intoxicated with stimulants, cannabis, the opioid meperidine, or phencyclidine, or those withdrawing from alcohol or sedatives, may experience altered perceptions that they recognize as drug effects. If reality testing for these experiences remains intact (i.e., the individual recognizes that the perception is substance induced and neither believes in nor acts on it), the diagnosis is not substance/medication-induced psychotic disorder. Instead, substance intoxication or substance withdrawal, with perceptual disturbances, is diagnosed (e.g., cocaine intoxication, with perceptual disturbances). "Flashback" hallucinations that can occur long after the use of hallucinogens has stopped are diagnosed as hallucinogen persisting perception disorder. If substance/medication-induced psychotic symptoms occur exclusively during the course of a delirium, as in severe forms of alcohol withdrawal, the psychotic symptoms are considered to be an associated feature of the delirium and are not diagnosed separately. Delusions in the context of a major or mild neurocognitive disorder would be diagnosed as major or mild neurocognitive disorder, with behavioral disturbance.

Primary psychotic disorder. A substance/medication-induced psychotic disorder is distinguished from a primary psychotic disorder, such as schizophrenia, schizoaffective disorder, delusional disorder, brief psychotic disorder, other specified schizophrenia spectrum and other psychotic disorder, or unspecified schizophrenia spectrum and other psychotic disorder, by the fact that a substance is judged to be etiologically related to the symptoms.

Psychotic disorder due to another medical condition. A substance/medication-induced psychotic disorder due to a prescribed treatment for a mental or medical condition must have its onset while the individual is receiving the medication (or during withdrawal, if there is a withdrawal syndrome associated with the medication). Because individuals with medical conditions often take medications for those conditions, the clinician must consider the possibility that the psychotic symptoms are caused by the physiological consequences of the medical condition rather than the medication, in which case psychotic disorder due to another medical condition is diagnosed. The history often provides the primary basis for such a judgment. At times, a change in the treatment for the medical condition (e.g., medication substitution or discontinuation) may be needed to determine empirically for that individual whether the medication is the causative agent. If the clinician has ascertained that the disturbance is attributable to both a medical condition and substance/medication use, both diagnoses (i.e., psychotic disorder due to another medical condition and substance/medication-induced psychotic disorder) may be given.

Psychotic Disorder Due to Another Medical Condition

Diagnostic Criteria

- A. Prominent hallucinations or delusions.
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder.
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify whether:

Code based on predominant symptom:

293.81 (F06.2) With delusions: If delusions are the predominant symptom.

293.82 (F06.0) With hallucinations: If hallucinations are the predominant symptom.

Coding note: Include the name of the other medical condition in the name of the mental disorder (e.g., 293.81 [F06.2] psychotic disorder due to malignant lung neoplasm, with delusions). The other medical condition should be coded and listed separately immediately before the psychotic disorder due to the medical condition (e.g., 162.9 [C34.90] malignant lung neoplasm; 293.81 [F06.2] psychotic disorder due to malignant lung neoplasm, with delusions).

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and

severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)

Note: Diagnosis of psychotic disorder due to another medical condition can be made without using this severity specifier.

Specifiers

In addition to the symptom domain areas identified in the diagnostic criteria, the assessment of cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders.

Diagnostic Features

The essential features of psychotic disorder due to another medical condition are prominent delusions or hallucinations that are judged to be attributable to the physiological effects of another medical condition and are not better explained by another mental disorder (e.g., the symptoms are not a psychologically mediated response to a severe medical condition, in which case a diagnosis of brief psychotic disorder, with marked stressor, would be appropriate).

Hallucinations can occur in any sensory modality (i.e., visual, olfactory, gustatory, tactile, or auditory), but certain etiological factors are likely to evoke specific hallucinatory phenomena. Olfactory hallucinations are suggestive of temporal lobe epilepsy. Hallucinations may vary from simple and unformed to highly complex and organized, depending on etiological and environmental factors. Psychotic disorder due to another medical condition is generally not diagnosed if the individual maintains reality testing for the hallucinations and appreciates that they result from the medical condition. Delusions may have a variety of themes, including somatic, grandiose, religious, and, most commonly, persecutory. On the whole, however, associations between delusions and particular medical conditions appear to be less specific than is the case for hallucinations.

In determining whether the psychotic disturbance is attributable to another medical condition, the presence of a medical condition must be identified and considered to be the etiology of the psychosis through a physiological mechanism. Although there are no infallible guidelines for determining whether the relationship between the psychotic disturbance and the medical condition is etiological, several considerations provide some guidance. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the medical condition and that of the psychotic disturbance. A second consideration is the presence of features that are atypical for a psychotic disorder (e.g., atypical age at onset or presence of visual or olfactory hallucinations). The disturbance must also be distinguished from a substance/medication-induced psychotic disorder or another mental disorder (e.g., an adjustment disorder).

Associated Features Supporting Diagnosis

The temporal association of the onset or exacerbation of the medical condition offers the greatest diagnostic certainty that the delusions or hallucinations are attributable to a medical condition. Additional factors may include concomitant treatments for the underlying medical condition that confer a risk for psychosis independently, such as steroid treatment for autoimmune disorders.

Prevalence

Prevalence rates for psychotic disorder due to another medical condition are difficult to estimate given the wide variety of underlying medical etiologies. Lifetime prevalence has

been estimated to range from 0.21% to 0.54%. When the prevalence findings are stratified by age group, individuals older than 65 years have a significantly greater prevalence of 0.74% compared with those in younger age groups. Rates of psychosis also vary according to the underlying medical condition; conditions most commonly associated with psychosis include untreated endocrine and metabolic disorders, autoimmune disorders (e.g., systemic lupus erythematosus, N-methyl-D-aspartate (NMDA) receptor autoimmune encephalitis), or temporal lobe epilepsy. Psychosis due to epilepsy has been further differentiated into ictal, postictal, and interictal psychosis. The most common of these is postictal psychosis, observed in 2%–7.8% of epilepsy patients. Among older individuals, there may be a higher prevalence of the disorder in females, although additional gender-related features are not clear and vary considerably with the gender distributions of the underlying medical conditions.

Development and Course

Psychotic disorder due to another medical condition may be a single transient state or it may be recurrent, cycling with exacerbations and remissions of the underlying medical condition. Although treatment of the underlying medical condition often results in a resolution of the psychosis, this is not always the case, and psychotic symptoms may persist long after the medical event (e.g., psychotic disorder due to focal brain injury). In the context of chronic conditions such as multiple sclerosis or chronic interictal psychosis of epilepsy, the psychosis may assume a long-term course.

The expression of psychotic disorder due to another medical condition does not differ substantially in phenomenology depending on age at occurrence. However, older age groups have a higher prevalence of the disorder, which is most likely due to the increasing medical burden associated with advanced age and the cumulative effects of deleterious exposures and age-related processes (e.g., atherosclerosis). The nature of the underlying medical conditions is likely to change across the lifespan, with younger age groups more affected by epilepsy, head trauma, autoimmune, and neoplastic diseases of early to mid-life, and older age groups more affected by stroke disease, anoxic events, and multiple system comorbidities. Underlying factors with increasing age, such as preexisting cognitive impairment as well as vision and hearing impairments, may incur a greater risk for psychosis, possibly by serving to lower the threshold for experiencing psychosis.

Risk and Prognostic Factors

Course modifiers. Identification and treatment of the underlying medical condition has the greatest impact on course, although preexisting central nervous system injury may confer a worse course outcome (e.g., head trauma, cerebrovascular disease).

Diagnostic Markers

The diagnosis of psychotic disorder due to another medical condition depends on the clinical condition of each individual, and the diagnostic tests will vary according to that condition. A variety of medical conditions may cause psychotic symptoms. These include neurological conditions (e.g., neoplasms, cerebrovascular disease, Huntington's disease, multiple sclerosis, epilepsy, auditory or visual nerve injury or impairment, deafness, migraine, central nervous system infections), endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism), metabolic conditions (e.g., hypoxia, hypercarbia, hypoglycemia), fluid or electrolyte imbalances, hepatic or renal diseases, and autoimmune disorders with central nervous system involvement (e.g., systemic lupus erythematosus). The associated physical examination findings, laboratory findings, and patterns of prevalence or onset reflect the etiological medical condition.

Suicide Risk

Suicide risk in the context of psychotic disorder due to another medical condition is not clearly delineated, although certain conditions such as epilepsy and multiple sclerosis are associated with increased rates of suicide, which may be further increased in the presence of psychosis.

Functional Consequences of Psychotic Disorder Due to Another Medical Condition

Functional disability is typically severe in the context of psychotic disorder due to another medical condition but will vary considerably by the type of condition and likely improve with successful resolution of the condition.

Differential Diagnosis

Delirium. Hallucinations and delusions commonly occur in the context of a delirium; however, a separate diagnosis of psychotic disorder due to another medical condition is not given if the disturbance occurs exclusively during the course of a delirium. Delusions in the context of a major or mild neurocognitive disorder would be diagnosed as major or mild neurocognitive disorder, with behavioral disturbance.

Substance/medication-induced psychotic disorder. If there is evidence of recent or prolonged substance use (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin (e.g., LSD [lysergic acid diethylamide] intoxication, alcohol withdrawal), a substance/medication-induced psychotic disorder should be considered. Symptoms that occur during or shortly after (i.e., within 4 weeks) of substance intoxication or withdrawal or after medication use may be especially indicative of a substance-induced psychotic disorder, depending on the character, duration, or amount of the substance used. If the clinician has ascertained that the disturbance is due to both a medical condition and substance use, both diagnoses (i.e., psychotic disorder due to another medical condition and substance/medication-induced psychotic disorder) can be given.

Psychotic disorder. Psychotic disorder due to another medical condition must be distinguished from a psychotic disorder (e.g., schizophrenia, delusional disorder, schizoaffective disorder) or a depressive or bipolar disorder, with psychotic features. In psychotic disorders and in depressive or bipolar disorders, with psychotic features, no specific and direct causative physiological mechanisms associated with a medical condition can be demonstrated. Late age at onset and the absence of a personal or family history of schizophrenia or delusional disorder suggest the need for a thorough assessment to rule out the diagnosis of psychotic disorder due to another medical condition. Auditory hallucinations that involve voices speaking complex sentences are more characteristic of schizophrenia than of psychotic disorder due to a medical condition. Other types of hallucinations (e.g., visual, olfactory) commonly signal a psychotic disorder due to another medical condition or a substance/medication-induced psychotic disorder.

Comorbidity

Psychotic disorder due to another medical condition in individuals older than 80 years is associated with concurrent major neurocognitive disorder (dementia).

Catatonia

Catatonia can occur in the context of several disorders, including neurodevelopmental, psychotic, bipolar, depressive disorders, and other medical conditions (e.g., cerebral folate deficiency, rare autoimmune and paraneoplastic disorders). The manual does not treat catatonia as an independent class but recognizes a) catatonia associated with another mental disorder (i.e., a neurodevelopmental, psychotic disorder, a bipolar disorder, a depressive disorder, or other mental disorder), b) catatonic disorder due to another medical condition, and c) unspecified catatonia.

Catatonia is defined by the presence of three or more of 12 psychomotor features in the diagnostic criteria for catatonia associated with another mental disorder and catatonic disorder due to another medical condition. The essential feature of catatonia is a marked psychomotor disturbance that may involve decreased motor activity, decreased engagement during interview or physical examination, or excessive and peculiar motor activity. The clinical presentation of catatonia can be puzzling, as the psychomotor disturbance may range from marked unresponsiveness to marked agitation. Motoric immobility may be severe (stupor) or moderate (catalepsy and waxy flexibility). Similarly, decreased engagement may be severe (mutism) or moderate (negativism). Excessive and peculiar motor behaviors can be complex (e.g., stereotypy) or simple (agitation) and may include echolalia and echopraxia. In extreme cases, the same individual may wax and wane between decreased and excessive motor activity. The seemingly opposing clinical features and variable manifestations of the diagnosis contribute to a lack of awareness and decreased recognition of catatonia. During severe stages of catatonia, the individual may need careful supervision to avoid self-harm or harming others. There are potential risks from malnutrition, exhaustion, hyperpyrexia and self-inflicted injury.

Catatonia Associated With Another Mental Disorder (Catatonia Specifier)

293.89 (F06.1)

A. The clinical picture is dominated by three (or more) of the following symptoms:

1. Stupor (i.e., no psychomotor activity; not actively relating to environment).
2. Catalepsy (i.e., passive induction of a posture held against gravity).
3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner).
4. Mutism (i.e., no, or very little, verbal response [exclude if known aphasia]).
5. Negativism (i.e., opposition or no response to instructions or external stimuli).
6. Posturing (i.e., spontaneous and active maintenance of a posture against gravity).
7. Mannerism (i.e., odd, circumstantial caricature of normal actions).
8. Stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements).
9. Agitation, not influenced by external stimuli.
10. Grimacing.
11. Echolalia (i.e., mimicking another's speech).
12. Echopraxia (i.e., mimicking another's movements).

Coding note: Indicate the name of the associated mental disorder when recording the name of the condition (i.e., 293.89 [F06.1] catatonia associated with major depressive disorder). Code first the associated mental disorder (e.g., neurodevelopmental disorder, brief

psychotic disorder, schizophasic disorder, schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, or other mental disorder) (e.g., 295.70 [F25.1] schizoaffective disorder, depressive type; 293.89 [F06.1] catatonia associated with schizoaffective disorder).

Diagnostic Features

Catatonia associated with another mental disorder (catatonia specifier) may be used when criteria are met for catatonia during the course of a neurodevelopmental, psychotic, bipolar, depressive, or other mental disorder. The catatonia specifier is appropriate when the clinical picture is characterized by marked psychomotor disturbance and involves at least three of the 12 diagnostic features listed in Criterion A. Catatonia is typically diagnosed in an inpatient setting and occurs in up to 35% of individuals with schizophrenia, but the majority of catatonia cases involve individuals with depressive or bipolar disorders. Before the catatonia specifier is used in neurodevelopmental, psychotic, bipolar, depressive, or other mental disorders, a wide variety of other medical conditions need to be ruled out; these conditions include, but are not limited to, medical conditions due to infectious, metabolic, or neurological conditions (see "Catatonic Disorder Due to Another Medical Condition"). Catatonia can also be a side effect of a medication (see the chapter "Medication-Induced Movement Disorders and Other Adverse Effects of Medication"). Because of the seriousness of the complications, particular attention should be paid to the possibility that the catatonia is attributable to 333.92 (G21.0) neuroleptic malignant syndrome.

Catatonic Disorder Due to Another Medical Condition

Diagnostic Criteria

293.89 (F06.1)

- A. The clinical picture is dominated by three (or more) of the following symptoms:
 - 1. Stupor (i.e., no psychomotor activity; not actively relating to environment).
 - 2. Catalepsy (i.e., passive induction of a posture held against gravity).
 - 3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner).
 - 4. Mutism (i.e., no, or very little, verbal response [**Note:** not applicable if there is an established aphasia]).
 - 5. Negativism (i.e., opposition or no response to instructions or external stimuli).
 - 6. Posturing (i.e., spontaneous and active maintenance of a posture against gravity).
 - 7. Mannerism (i.e., odd, circumstantial caricature of normal actions).
 - 8. Stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements).
 - 9. Agitation, not influenced by external stimuli.
 - 10. Grimacing.
 - 11. Echolalia (i.e., mimicking another's speech).
 - 12. Echopraxia (i.e., mimicking another's movements).
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder (e.g., a manic episode).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.