

disorder is not a distinct nosological category. Thus, dimensional assessments of depression and mania for all psychotic disorders alert clinicians to mood pathology and the need to treat where appropriate. The Section III scale also includes a dimensional assessment of cognitive impairment. Many individuals with psychotic disorders have impairments in a range of cognitive domains that predict functional status. Clinical neuropsychological assessment can help guide diagnosis and treatment, but brief assessments without formal neuropsychological assessment can provide useful information that can be sufficient for diagnostic purposes. Formal neuropsychological testing, when conducted, should be administered and scored by personnel trained in the use of testing instruments. If a formal neuropsychological assessment is not conducted, the clinician should use the best available information to make a judgment. Further research on these assessments is necessary in order to determine their clinical utility; thus, the assessments available in Section III should serve as a prototype to stimulate such research.

## Schizotypal (Personality) Disorder

Criteria and text for schizotypal personality disorder can be found in the chapter “Personality Disorders.” Because this disorder is considered part of the schizophrenia spectrum of disorders, and is labeled in this section of ICD-9 and ICD-10 as schizotypal disorder, it is listed in this chapter and discussed in detail in the DSM-5 chapter “Personality Disorders.”

## Delusional Disorder

Diagnostic Criteria	297.1 (F22)
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- A. The presence of one (or more) delusions with a duration of 1 month or longer.
- B. Criterion A for schizophrenia has never been met.  
**Note:** Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).
- C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.
- D. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
- E. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

*Specify whether:*

- Erotomanic type:** This subtype applies when the central theme of the delusion is that another person is in love with the individual.
- Grandiose type:** This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.
- Jealous type:** This subtype applies when the central theme of the individual's delusion is that his or her spouse or lover is unfaithful.
- Persecutory type:** This subtype applies when the central theme of the delusion involves the individual's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.
- Somatic type:** This subtype applies when the central theme of the delusion involves bodily functions or sensations.

**Mixed type:** This subtype applies when no one delusional theme predominates.

**Unspecified type:** This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

*Specify if:*

**With bizarre content:** Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., an individual's belief that a stranger has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars).

*Specify if:*

The following course specifiers are only to be used after a 1-year duration of the disorder:

**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, 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 delusional disorder can be made without using this severity specifier.

## Subtypes

In *erotomanic type*, the central theme of the delusion is that another person is in love with the individual. The person about whom this conviction is held is usually of higher status (e.g., a famous individual or a superior at work) but can be a complete stranger. Efforts to contact the object of the delusion are common. In *grandiose type*, the central theme of the delusion is the conviction of having some great talent or insight or of having made some important discovery. Less commonly, the individual may have the delusion of having a special relationship with a prominent individual or of being a prominent person (in which case the actual individual may be regarded as an impostor). Grandiose delusions may have a religious content. In *jealous type*, the central theme of the delusion is that of an unfaithful partner. This belief is arrived at without due cause and is based on incorrect inferences supported by small bits of "evidence" (e.g., disarrayed clothing). The individual with the delusion usually confronts the spouse or lover and attempts to intervene in the imagined infidelity. In *persecutory type*, the central theme of the delusion involves the in-

individual's belief of being conspired against, cheated, spied on, followed, poisoned, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals. Small slights may be exaggerated and become the focus of a delusional system. The affected individual may engage in repeated attempts to obtain satisfaction by legal or legislative action. Individuals with persecutory delusions are often resentful and angry and may resort to violence against those they believe are hurting them. In *somatic type*, the central theme of the delusion involves bodily functions or sensations. Somatic delusions can occur in several forms. Most common is the belief that the individual emits a foul odor; that there is an infestation of insects on or in the skin; that there is an internal parasite; that certain parts of the body are misshapen or ugly; or that parts of the body are not functioning.

## Diagnostic Features

The essential feature of delusional disorder is the presence of one or more delusions that persist for at least 1 month (Criterion A). A diagnosis of delusional disorder is not given if the individual has ever had a symptom presentation that met Criterion A for schizophrenia (Criterion B). Apart from the direct impact of the delusions, impairments in psychosocial functioning may be more circumscribed than those seen in other psychotic disorders such as schizophrenia, and behavior is not obviously bizarre or odd (Criterion C). If mood episodes occur concurrently with the delusions, the total duration of these mood episodes is brief relative to the total duration of the delusional periods (Criterion D). The delusions are not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., Alzheimer's disease) and are not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder (Criterion E).

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

Social, marital, or work problems can result from the delusional beliefs of delusional disorder. Individuals with delusional disorder may be able to factually describe that others view their beliefs as irrational but are unable to accept this themselves (i.e., there may be "factual insight" but no true insight). Many individuals develop irritable or dysphoric mood, which can usually be understood as a reaction to their delusional beliefs. Anger and violent behavior can occur with persecutory, jealous, and erotomanic types. The individual may engage in litigious or antagonistic behavior (e.g., sending hundreds of letters of protest to the government). Legal difficulties can occur, particularly in jealous and erotomanic types.

## Prevalence

The lifetime prevalence of delusional disorder has been estimated at around 0.2%, and the most frequent subtype is persecutory. Delusional disorder, jealous type, is probably more common in males than in females, but there are no major gender differences in the overall frequency of delusional disorder.

## Development and Course

On average, global function is generally better than that observed in schizophrenia. Although the diagnosis is generally stable, a proportion of individuals go on to develop

schizophrenia. Delusional disorder has a significant familial relationship with both schizophrenia and schizotypal personality disorder. Although it can occur in younger age groups, the condition may be more prevalent in older individuals.

## Culture-Related Diagnostic Issues

An individual's cultural and religious background must be taken into account in evaluating the possible presence of delusional disorder. The content of delusions also varies across cultural contexts.

## Functional Consequences of Delusional Disorder

The functional impairment is usually more circumscribed than that seen with other psychotic disorders, although in some cases, the impairment may be substantial and include poor occupational functioning and social isolation. When poor psychosocial functioning is present, delusional beliefs themselves often play a significant role. A common characteristic of individuals with delusional disorder is the apparent normality of their behavior and appearance when their delusional ideas are not being discussed or acted on.

## Differential Diagnosis

**Obsessive-compulsive and related disorders.** If an individual with obsessive-compulsive disorder is completely convinced that his or her obsessive-compulsive disorder beliefs are true, then the diagnosis of obsessive-compulsive disorder, with absent insight/delusional beliefs specifier, should be given rather than a diagnosis of delusional disorder. Similarly, if an individual with body dysmorphic disorder is completely convinced that his or her body dysmorphic disorder beliefs are true, then the diagnosis of body dysmorphic disorder, with absent insight/delusional beliefs specifier, should be given rather than a diagnosis of delusional disorder.

**Delirium, major neurocognitive disorder, psychotic disorder due to another medical condition, and substance/medication-induced psychotic disorder.** Individuals with these disorders may present with symptoms that suggest delusional disorder. For example, simple persecutory delusions in the context of major neurocognitive disorder would be diagnosed as major neurocognitive disorder, with behavioral disturbance. A substance/medication-induced psychotic disorder cross-sectionally may be identical in symptomatology to delusional disorder but can be distinguished by the chronological relationship of substance use to the onset and remission of the delusional beliefs.

**Schizophrenia and schizophreniform disorder.** Delusional disorder can be distinguished from schizophrenia and schizophreniform disorder by the absence of the other characteristic symptoms of the active phase of schizophrenia.

**Depressive and bipolar disorders and schizoaffective disorder.** These disorders may be distinguished from delusional disorder by the temporal relationship between the mood disturbance and the delusions and by the severity of the mood symptoms. If delusions occur exclusively during mood episodes, the diagnosis is depressive or bipolar disorder with psychotic features. Mood symptoms that meet full criteria for a mood episode can be superimposed on delusional disorder. Delusional disorder can be diagnosed only if the total duration of all mood episodes remains brief relative to the total duration of the delusional disturbance. If not, then a diagnosis of other specified or unspecified schizophrenia spectrum and other psychotic disorder accompanied by other specified depressive disorder, unspecified depressive disorder, other specified bipolar and related disorder, or unspecified bipolar and related disorder is appropriate.

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 schizophreniform disorder and schizophrenia differ primarily in duration of illness, the discussion of the differential diagnosis of schizophrenia also applies to schizophreniform disorder.

**Brief psychotic disorder.** Schizophreniform 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 phobias 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 trau-

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

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## Diagnostic Criteria

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- 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

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### Diagnostic Criteria

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- 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.