02 - Schizophrenia Spectrum and Other Psychotic Di

Schizophrenia Spectrum and Other Psychotic Disorders

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Schizophrenia Spectrum and Other Psychotic Disorders Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms. Key Features That Define the Psychotic Disorders Delusions Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, grandiose). Persecutory delusions (i.e., belief that one is going to be harmed, harassed, and so forth by an individual, organization, or other group) are most common. Referential delusions (i.e., belief that certain gestures, comments, environmental cues, and so forth are directed at oneself) are also common. Grandiose delusions (i.e., when an individual believes that he or she has exceptional abilities, wealth, or fame) and erotomanic delusions (i.e., when an individual believes falsely that another person is in love with him or her) are also seen. Nihilistic delusions involve the conviction that a major catastrophe will occur, and somatic delusions focus on preoccupations regarding health and organ function. Delusions are deemed bizarre if they are clearly implausible and not understandable to sameculture peers and do not derive from ordinary life experiences. An example of a bizarre delusion is the belief that an outside force has removed his or her internal organs and replaced them with someone else’s organs without leaving any wounds or scars. An example of a nonbizarre delusion is the belief that one is under surveillance by the police, despite a lack of convincing evidence. Delusions that express a loss of control over mind or body are generally considered to be bizarre; these include the belief that one’s thoughts have been “removed” by some outside force (thought withdrawal), that alien thoughts have been put into one’s mind (thought insertion), or that one’s body or actions are being acted on or manipulated by some outside force (delusions of control). The distinction between a delusion and a strongly held idea is sometimes difficult to determine and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.

Assessing delusions in individuals from a variety of cultural backgrounds can be difficult. Some religious and supernatural beliefs (e.g., evil eye, causing illness through curses, influence of spirits) may be viewed as bizarre and possibly delusional in some cultural contexts but be generally accepted in

others. However, elevated religiosity can be a feature of many presentations of psychosis. Individuals who have experienced torture, political violence, or discrimination can report fears that may be misjudged as persecutory delusions; these may represent instead intense fears of recurrence or posttraumatic symptoms. A careful evaluation of whether the person's fears are justified given the nature of the trauma can help to differentiate appropriate fears from persecutory delusions. Hallucinations Hallucinations are perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control. They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the individual's own thoughts. The hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (hypnagogic) or waking up (hypnopompic) are considered to be within the range of normal experience. Hallucinations may be a normal part of religious experience in certain cultural contexts. Disorganized Thinking (Speech) Disorganized thinking (formal thought disorder) is typically inferred from the individual's speech. The individual may switch from one topic to another (derailment or loose associations). Answers to questions may be obliquely related or completely unrelated (tangentiality). Rarely, speech may be so severely disorganized that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganization (incoherence or "word salad"). Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication. The severity of the impairment may be difficult to evaluate if the person making the diagnosis comes from a different linguistic background than that of the person being examined. For example, some religious groups engage in glossolalia ("speaking in tongues"); others describe experiences of possession trance (trance states in which personal identity is replaced by an external possessing identity). These phenomena are characterized by disorganized speech. These instances do not represent signs of psychosis unless they are accompanied by other clearly psychotic symptoms. Less severe disorganized thinking or speech may occur during the prodromal and residual periods of schizophrenia. Grossly Disorganized or Abnormal Motor Behavior (Including Catatonia) Grossly disorganized or abnormal motor behavior may manifest itself in a variety of ways, ranging from childlike "silliness" to unpredictable agitation. Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living. Catatonic behavior is a marked decrease in reactivity to the environment. This ranges from resistance to instructions (negativism); to maintaining a rigid, inappropriate or bizarre posture; to a complete lack of verbal and motor responses (mutism and stupor). It can also include

purposeless and excessive motor activity without obvious cause (catatonic excitement). Other features are repeated stereotyped movements, staring, grimacing, and the echoing of speech. Although catatonia has historically been associated with schizophrenia, catatonic symptoms are nonspecific and may occur in other mental disorders (e.g., bipolar or depressive disorders with catatonia) and in medical conditions (catatonic disorder due to another medical condition). Negative Symptoms Negative symptoms account for a substantial portion of the morbidity

associated with schizophrenia but are less prominent in other psychotic disorders. Two negative symptoms are particularly prominent in schizophrenia: diminished emotional expression and avolition. Diminished emotional expression includes reductions in the expression of emotions in the face, eye contact, intonation of speech (prosody), and movements of the hand, head, and face that normally give an emotional emphasis to speech. Avolition is a decrease in motivated selfinitiated purposeful activities. The individual may sit for long periods of time and show little interest in participating in work or social activities. Other negative symptoms include alogia, anhedonia, and asociality. Alogia is manifested by diminished speech output. Anhedonia is the decreased ability to experience pleasure. Individuals with schizophrenia can still enjoy a pleasurable activity in the moment and can recall it, but show a reduction in the frequency of engaging in pleasurable activity. Asociality refers to the apparent lack of interest in social interactions and may be associated with avolition, but it can also be a manifestation of limited opportunities for social interactions. Disorders in This Chapter This chapter is organized along a gradient of psychopathology. Clinicians should first consider conditions that do not reach full criteria for a psychotic disorder or are limited to one domain of psychopathology. Then they should consider time-limited conditions. Finally, the diagnosis of a schizophrenia spectrum disorder requires the exclusion of another condition that may give rise to psychosis. Schizotypal personality disorder is noted within this chapter as it is considered within the schizophrenia spectrum, although its full description is found in the chapter “Personality Disorders.” The diagnosis schizotypal personality disorder captures a pervasive pattern of social and interpersonal deficits, including reduced capacity for close relationships; cognitive or perceptual distortions; and eccentricities of behavior, usually beginning by early adulthood but in some cases first becoming apparent in childhood and adolescence. Abnormalities of beliefs, thinking, and perception are below the threshold for the diagnosis of a psychotic disorder. Two conditions are defined by abnormalities limited to one domain of psychosis: delusions or catatonia. Delusional disorder is characterized by at least 1 month of delusions but no other psychotic symptoms. Catatonia is described later in the chapter and further in this discussion. Brief psychotic disorder lasts more than 1 day and remits by 1 month. Schizophreniform disorder is characterized by a symptomatic presentation equivalent to that of schizophrenia except for its duration (less than 6 months) and the absence of a requirement for a decline in

functioning. Schizophrenia lasts for at least 6 months and includes at least 1 month of active-phase symptoms. In schizoaffective disorder, a mood episode and the active-phase symptoms of schizophrenia occur together and were preceded or are followed by at least 2 weeks of delusions or hallucinations without prominent mood symptoms. Psychotic disorders may be induced by substances, medications, toxins, and other medical conditions. In substance/medication-induced psychotic disorder, the psychotic symptoms are judged to be a direct physiological consequence of a drug of abuse, a medication, or toxin exposure and cease after removal of the agent. In psychotic disorder due to another medical condition, the psychotic symptoms are judged to be a direct physiological consequence of another medical condition. Catatonia can occur in several disorders, including neurodevelopmental, psychotic, bipolar, depressive, and other mental disorders. This chapter also includes the diagnoses catatonia associated with another mental disorder (catatonia specifier), catatonic disorder due to another medical condition, and unspecified catatonia, and the diagnostic criteria for all three conditions are described together. Other specified and unspecified schizophrenia spectrum and other psychotic disorders are included for classifying psychotic presentations that do not meet the criteria for any of the specific psychotic disorders, or psychotic

symptomatology about which there is inadequate or contradictory information. Clinician-Rated Assessment of Symptoms and Related Clinical Phenomena in Psychosis Psychotic disorders are heterogeneous, and the severity of symptoms can predict important aspects of the illness, such as the degree of cognitive or neurobiological deficits. To move the field forward, a detailed framework for the assessment of severity is included in Section III, “Assessment Measures,” which may help with treatment planning, prognostic decision-making, and research on pathophysiological mechanisms. Section III, “Assessment Measures,” also contains dimensional assessments of the primary symptoms of psychosis, including hallucinations, delusions, disorganized speech (except for substance/medication-induced psychotic disorder and psychotic disorder due to another medical condition), abnormal psychomotor behavior, and negative symptoms, as well as dimensional assessments of depression and mania. The severity of mood symptoms in psychosis has prognostic value and guides treatment. 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

F22 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 to determine their clinical utility; thus, the assessments available in Section III should serve as a prototype to stimulate such research. Cultural Considerations in the Assessment of Psychotic Symptoms Diagnostic accuracy and the quality of treatment planning may be enhanced by interview approaches, scales, and tools that have been adapted or validated for the person’s culture and by using a cultural formulation interview (see Section III, “Culture and Psychiatric Diagnosis”). Assessing psychosis through interpreters or in a second or third language must avoid the misunderstanding of unfamiliar metaphors as delusions. 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-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 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 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; 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

Genetic and physiological. 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 delusions 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. Whereas delusions are a sine qua non of delusional disorder, hallucinations and negative symptoms are uncommon and disorganization is rare. By definition, the presence of catatonia in conjunction with delusions rules out delusional disorder, because Criterion A for schizophrenia would be met. A subset of cases has prominent depressive symptoms, but cognitive impairment and mania are rarely demonstrated. Associated Features 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 sometimes 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% in a Finnish sample, and the most frequent subtype is persecutory. Delusional disorder, jealous type, is probably more common in men than in women, but there are no major sex or gender differences in the overall frequency of delusional disorder or in the content of the delusions. Development and Course On average, global functioning is generally better than that observed in schizophrenia. Although the diagnosis is generally stable, a proportion of individuals go on to develop schizophrenia. Whereas about a third of individuals with delusional disorder of 1–3 months’ duration subsequently receive a diagnosis of schizophrenia, the diagnosis of delusional disorder is much less likely to change if the duration of the disorder is greater than 6–12 months. Although delusional disorder can occur in younger age groups, it may be more prevalent in older individuals. Risk and Prognostic Factors Delusional disorder has a significant familial relationship with both schizophrenia and schizotypal personality

disorder.

Obsessive-compulsive and related disorders. Delirium, major neurocognitive disorder, and psychotic disorder due to another medical condition. Substance/medication-induced psychotic disorder. Schizophrenia and schizophreniform disorder. Culture-Related Diagnostic Issues An individual's cultural and religious background must be taken into account in evaluating the possible presence of delusional disorder; in fact, some traditional beliefs unfamiliar to Western cultures may be wrongly labeled as delusional, so their context must be carefully assessed. The nature and content of delusions also vary among different cultural groups. 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. Men with delusional disorder generally have more severe symptoms and worse functional outcomes compared with women. Differential Diagnosis 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. 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. Delusional disorder can be distinguished from schizophrenia and schizophreniform disorder by the absence of the other characteristic symptoms of the active phase of schizophrenia. Furthermore, the quality of delusions can help distinguish between schizophrenia and delusional disorder. In schizophrenia, delusions show greater disorganization (the degree to which delusions are internally consistent, logical, and systematized), whereas in delusional disorder, they show greater conviction (the degree to which the individual is convinced of the reality of the delusion), greater extension (the degree to which the delusion involves various areas of the individual's life), and greater pressure (the degree to

Depressive and bipolar disorders and schizoaffective disorder. F23 which the individual is preoccupied and concerned with the expressed delusion). 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 major 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. Brief Psychotic Disorder Diagnostic Criteria A. Presence of one (or more) of the following symptoms. 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. Note: Do not include a symptom if it is a culturally sanctioned response. B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning. C. The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder such as schizophrenia or catatonia, and 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 marked stressor(s) (brief reactive psychosis): If symptoms occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture. Without marked stressor(s): If symptoms do not occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture. With peripartum onset: If onset is during pregnancy or within 4 weeks

postpartum. Specify if: With catatonia (refer to the criteria for catatonia associated with another mental disorder, p. 135, for definition). Coding note: Use additional code F06.1 catatonia associated with brief psychotic 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 ClinicianRated Dimensions of Psychosis Symptom Severity in the chapter "Assessment Measures.") Note: Diagnosis of brief psychotic disorder can be made without using this severity specifier. Diagnostic Features The essential feature of brief psychotic disorder is a disturbance that involves at least one of the following positive psychotic symptoms: delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), or grossly abnormal psychomotor behavior, including catatonia (Criterion A). An episode of the disturbance lasts at least 1 day but less than 1 month, and the individual eventually has a full return to the premorbid level of functioning (Criterion B). The disturbance is not better explained by a depressive or bipolar disorder with psychotic features, by schizoaffective disorder, or by schizophrenia and is not attributable to the physiological effects of a substance (e.g., a hallucinogen) or another medical condition (e.g., subdural hematoma) (Criterion C). 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 Individuals with brief psychotic disorder typically experience emotional turmoil or overwhelming confusion. They may have rapid shifts from one intense affect to another. Although the disturbance is brief, the level of impairment may be severe, and supervision may be required to ensure that nutritional and hygienic needs are

met and that the individual is protected from the consequences of poor judgment, cognitive impairment, or acting on the basis of delusions. There appears to be an increased risk of suicidal behavior, particularly during the acute episode. Prevalence

Other medical conditions. Substance-related disorders. Depressive and bipolar disorders. Brief psychotic disorder may account for 2%–7% of cases of first-onset psychosis in several countries. Development and Course Brief psychotic disorder may appear in adolescence or early adulthood, and onset can occur across the life span, with the average age at onset being the mid 30s. By definition, a diagnosis of brief psychotic disorder requires a full remission of all symptoms and an eventual full return to the premorbid level of functioning within 1 month of the onset of the disturbance. In some individuals, the duration of psychotic symptoms may be quite brief (e.g., a few days). Although brief psychotic disorder by definition reaches a full remission within 1 month, subsequently more than 50% of the individuals experience a relapse. Despite the possibility of relapse, for most individuals, outcome is favorable in terms of social functioning and symptomatology. In less than half of cases diagnosed with DSM-IV brief psychotic disorder or ICD-10 acute and transient psychotic disorder, the diagnosis changes—more often to schizophrenia spectrum disorders and less often to affective disorders or to other psychotic disorders. Culture-Related Diagnostic Issues It is important to distinguish symptoms of brief psychotic disorder from culturally sanctioned response patterns. For example, in some religious ceremonies, an individual may report hearing voices, but these do not generally persist and are not perceived as abnormal by most members of the individual's community. In a wide range of cultural contexts, it would be common or expected for bereaved relatives to hear, see, or interact with the spirit of a recently deceased loved one without notable pathological sequelae. In addition, cultural and religious background must be taken into account when considering whether beliefs are delusional. Differential Diagnosis A variety of medical conditions 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/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. 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. Malingering and factitious disorders. Personality disorders. F20.81 If the psychotic symptoms persist for 1 month or longer, the diagnosis is either schizophreniform 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 schizophreniform 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. 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. 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. Schizophreniform Disorder Diagnostic Criteria 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, p. 135, for definition). Coding note: Use additional code 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 ClinicianRated 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, Development and Course (age-related factors), Culture-Related Diagnostic Issues, Sex- and 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

Genetic and physiological. 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 schizophreniform 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 schizophreniform 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 As with schizophrenia, currently there are no laboratory or psychometric tests for schizophreniform disorder. There are multiple brain regions where neuroimaging, neuropathological, and neurophysiological research has indicated abnormalities, but none are diagnostic. Prevalence Incidence of schizophreniform disorder across sociocultural settings is likely similar to that observed in schizophrenia. In the United States and other high-income countries, the incidence is low, possibly fivefold less than that of schizophrenia. In lower-income countries, the incidence may be higher, especially for the specifier "with good prognostic features"; in some of these settings schizophreniform disorder may be as common as schizophrenia. Development and Course The development of schizophreniform disorder is similar to that of schizophrenia. About onethird of individuals with an initial diagnosis of schizophreniform disorder (provisional) recover within the 6-month period and schizophreniform 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 Relatives of individuals with schizophreniform disorder have an increased risk for schizophrenia. Functional Consequences of Schizophreniform Disorder For the majority of individuals with schizophreniform 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

Other mental disorders and medical conditions. Brief psychotic disorder. F20.9 daily functioning, such as school or work, interpersonal relationships, and self-care. Individuals who recover from schizophreniform disorder have better functional outcomes. Differential Diagnosis A wide variety of mental disorders and medical conditions can manifest with psychotic symptoms that must be considered in the differential diagnosis of schizophreniform disorder. These include psychotic disorder due to another medical condition or its treatment; delirium or major neurocognitive disorder; substance/medicationinduced psychotic disorder or delirium; major depressive or bipolar disorder with psychotic features; schizoaffective disorder; other specified or unspecified bipolar and related disorder; major depressive or bipolar disorder with catatonic features; schizophrenia;

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; obsessivecompulsive 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. Schizophreniform disorder differs in duration from brief psychotic disorder, which has a duration of less than 1 month. Schizophrenia Diagnostic Criteria 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, p. 135, for definition). Coding note: Use additional code 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 ClinicianRated 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” 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 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 nonadherence 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, nonadherence to 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 estimated lifetime prevalence of schizophrenia is approximately 0.3%–0.7%, with variation over a fivefold range in meta-analyses of nationally representative surveys. Studies have shown increased prevalence and incidence of schizophrenia for some groups based on migration and refugee status, urbanicity, and the

economic status and latitude of the country. It is important to note that the reported prevalence and incidence of schizophrenia may be affected by the fact that some groups are more likely to be misdiagnosed or overdiagnosed. The sex ratio differs across samples and populations: for example, presentations with prominent negative symptoms and longer duration of disorder (associated with poorer outcome) show higher incidence rates for men, whereas definitions allowing for the inclusion of more mood symptoms and brief presentations (associated with better outcome) show equivalent risks for both sexes. A large worldwide study, which was based on a range of definitions of schizophrenia, found no difference in prevalence between the sexes. Development and Course The requisite psychotic features of the schizophrenia diagnosis typically emerge between the late teens and the mid-30s; onset prior to adolescence is rare. The peak onset age occurs in the earlyto mid-20s for men and in the late-20s for women. 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, particularly social withdrawal, emo-tional changes, and cognitive changes producing a deterioration in role functioning. Half of these individuals display depressive symptoms. Prognosis is influenced both by dura-tion and by severity of illness and gender. Men, especially those with long duration of psychosis before treatment and lower premorbid adjustment, have more prominent negative symptoms, cognitive impairment, and generally worse functional outcomes than women. Sociocognitive deficits may manifest during development and precede the emergence of psychosis, taking the form of stable impairments during adulthood, refractory to antipsychotic medications.

Environmental. Course and outcome in schizophrenia are heterogeneous, and prognosis is uncertain at the onset of psychosis. Although most individuals with schizophrenia remain vulnerable to exacerbation of psychotic symptoms and a chronic course defined by symptoms and functional impairment is common, many individuals experience periods of remission and even recovery. According to a meta-analysis of 79 longitudinal studies of first-episode psychosis with more than 1 year of follow-up, the pooled remission rate (qualitatively defined as mild or absent symptoms for at least 6 months) for first-episode schizophrenia was 56% and the pooled recovery rate (qualitatively defined as symptomatic and functional improvement for greater than 2 years) was 30%. A different meta-analysis of 50 studies of individuals with broadly defined schizophrenia (i.e., schizophrenia, schizophreniform, schizoaffective, or delusional disorder) found that the median proportion of individuals who met recovery criteria (at most mild symptoms and improvements in social and/or occupational functioning persisting for at least 2 years) was 13.5%. There is a tendency for reduced psychotic experiences during late life. In addition to psychosis, cognitive impairment and negative symptom pathology are core features of schizophrenia, and the course for these characteristic features is different from that of positive psychotic symptoms. Cognition tends to decline during development prior to full psychosis and is relatively stable over the longer term. Negative symptoms, if present during development, also tend to be relatively stable traits over time. Negative symptoms that begin after psychosis onset are more variable and may reflect secondary causes. A degree of chronicity is required for a diagnosis of schizophrenia, and long-term course reflects a need for mental health care and living support in many individuals. While schizophrenia is generally not a progressive neurodegenerative disorder, life challenges, changing lifestyle, and persistent symptoms may lead to progressive dysfunction in more severe chronic cases. 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 women, 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 midlife (e.g., prior to age 55 years). Risk and Prognostic Factors Season of birth has been linked to the incidence of schizophrenia, including late

Genetic and physiological. winter/early spring in some locations and summer for the deficit form of the disease. The incidence of schizophrenia and related disorders may be higher for children growing up in an urban environment, for refugees, for some migrant groups, and for socially oppressed groups facing discrimination. There is evidence that social deprivation, social adversity, and socioeconomic factors may be associated with increased rates of this disorder. Among individuals with schizophrenia and other psychotic disorders, the severity of positive and negative symptoms appears to be correlated with the severity of adverse childhood experiences, such as trauma and neglect. Higher rates of schizophrenia for some ethnic and racialized groups have been documented when they live in areas with lower proportions of people from the same ethnicity or racialized group. The reasons for this are not completely clear but appear related to several factors, including the following: 1) higher levels of discrimination or fear of discrimination; 2) less social support and more stigmatization of those with schizophrenia; 3) higher social isolation; and 4) decreased availability of and access to normalizing explanations of perceptual experiences and abnormal beliefs reported by individuals at high risk for developing schizophrenia. 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 The form and content of schizophrenia symptoms can vary cross-culturally, including the following ways: the relative proportion of visual and auditory hallucinations (e.g., while auditory hallucinations tend to be more common than visual hallucinations around the world, the relative proportion of visual hallucinations may be particularly higher in some regions compared with others); the specific content of the delusions (e.g., persecutory, grandiose, somatic) and hallucinations (e.g., command, abusive, religious); and the level of fear associated with them. 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 cultural context (e.g., evil

eye, causing illness through curses, influences of spirits) may be commonly held in others. In some cultural contexts, 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 individual's subgroup. Misdiagnosis of schizophrenia in individuals with mood disorders with psychotic features or with other psychiatric disorders is more likely to occur in members of underserved ethnic and racialized groups (in the United States, especially among African Americans). This may be attributable to clinical bias, racism, or discrimination leading to limited quality of information and potential misinterpretation of symptoms. Sex- and Gender-Related Diagnostic Issues A number of features distinguish the clinical expression of schizophrenia in women and men. The age at onset is later in women, with a second midlife peak. Symptoms tend to be more affect-laden among women, 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 women. There are, however, frequent exceptions to these general caveats. Psychotic symptoms have been observed to worsen during the premenstrual time period when estrogen levels are dropping; consequently, increased psychiatric admission rates are seen in women with schizophrenia just before and during menses. Lower estrogen levels resulting from menopause may be another factor associated with the second peak of onset in women in midlife. Similarly, psychotic symptoms appear to improve during pregnancy when estrogen levels are high and worsen again postpartum when estrogen levels precipitously drop. Association With Suicidal Thoughts or Behavior 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 men and women, although it may be especially high for younger men with comorbid substance use. Other risk factors include depressive symptoms, hopelessness, being unemployed, the period after a psychotic episode or hospital discharge, number of psychiatric admissions, closeness to onset of illness, and older age at illness onset. A systematic review and meta-analysis of longitudinal studies found that the odds of suicidal behavior during follow-up after first-episode psychosis were higher among individuals with depressive symptoms during first-episode psychosis compared with those without. A meta-analysis of a large number of studies of the relationship of schizophrenia with suicidal behavior found that alcohol, tobacco, and drug abuse; depression; number of hospitalizations; physical comorbidity; and family history of depression and suicidal behavior increased the risk of suicide attempt. Risk factors for suicide included male sex, being younger, having a higher IQ, history of attempts, hopelessness, and poor adherence to treatment. Functional Consequences of Schizophrenia Schizophrenia is associated with significant social and occupational dysfunction. Among

Major depressive or bipolar disorder with psychotic or catatonic features. Schizoaffective disorder. Schizophreniform disorder and brief psychotic disorder. Delusional disorder. Schizotypal personality disorder. Obsessive-compulsive disorder and body dysmorphic disorder. Posttraumatic stress disorder. Autism spectrum disorder or communication disorders. individuals with schizophrenia, deficits in reading ability are more severe than what would be predicted by the general cognitive impairments associated with the disorder. Such deficits can be conceptualized as a secondary or acquired dyslexia that underlies the academic impairment observed in schizophrenia. 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 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. 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. 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 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 may be distinguished from schizophrenia by subthreshold symptoms that are associated with persistent personality features. Individuals with obsessivecompulsive 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 may include flashbacks that have a hallucinatory quality, and hypervigilance may reach paranoid proportions. But a traumatic event and characteristic symptom features relating to reliving or reacting to the event are required to make the diagnosis of posttraumatic stress disorder. These disorders may also have symptoms resembling a psychotic episode but are distinguished by their respective deficits in social

Other mental disorders associated with a psychotic episode. Substance/medication-induced psychotic disorder. 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. 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 conditions 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: F25.0 Bipolar type: This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur. 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, p. 135, for definition). Coding note: Use additional code 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 ClinicianRated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”) Note: Diagnosis of schizoaffective disorder can be made without using this severity specifier. 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), C (6-month duration), 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 lifetime course of a psychotic 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 Occupational and social 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 provide definitive

assistance in making the diagnosis of schizoaffective disorder. Neuropsychological testing typically shows cognitive deficits in areas such as executive function, verbal memory, and speed of processing, and these may be less pronounced than in schizophrenia. Schizoaffective disorder is often characterized by gray matter volume loss on brain imaging, in much the same way that schizophrenia is. Prevalence Schizoaffective disorder appears to be about one-third as common as schizophrenia. Lifetime prevalence of schizoaffective disorder was estimated to be 0.3% in a Finnish sample and is higher in women than in men when DSM-IV diagnostic criteria were used. This rate would be expected to be lower because of the more stringent requirement of DSM-5 Criterion C (i.e., 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). Development and Course The typical age at onset of schizoaffective disorder is early adulthood, although onset can occur anytime 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, whereas others may be diagnosed with mood disorders before independent psychotic symptoms are detected. Conversely, some individuals will have a change in diagnosis from schizoaffective disorder to a mood disorder or to schizophrenia over time. A change in diagnosis from schizoaffective disorder to schizophrenia was more common than a change to mood disorder under DSM-IV criteria, and that difference is expected to be more pronounced under DSM-5 as the current Criterion C for schizoaffective disorder has become more stringent, requiring mood symptoms to be present for the majority of the illness as compared with the DSM-IV definition, which only required mood symptoms to be present for a “substantial” portion. The

Genetic and physiological. 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 4 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 7 months, with psychotic symptoms alone present during the initial 2 months, both depressive and psychotic symptoms present during the next 4 months, and psychotic symptoms alone present during the last month. In this instance, the depressive episode was present for a majority of the total duration of the psychotic disturbance, and thus the presentation qualifies for a diagnosis of schizoaffective disorder. The temporal relationship between the mood symptoms and the 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 Among individuals with schizophrenia, there may be an increased risk for schizoaffective disorder in first-degree relatives. The risk for schizoaffective disorder may also be increased among individuals who have a first-degree relative with bipolar disorder or schizoaffective disorder itself. The molecular genetic composite signatures known as polygenic risk scores for schizophrenia, bipolar disorder, and major depressive disorder may all be elevated in 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 cultural context (e.g., evil eye, causing illness through curses, influences of spirits) may be commonly held in others. There is also some evidence in the literature that African American and Hispanic populations whose symptoms meet criteria for schizoaffective disorder are more likely to be diagnosed with schizophrenia. To mitigate the impact of clinician

Other mental disorders and medical conditions. Psychotic disorder due to another medical condition. Schizophrenia, bipolar, and depressive disorders. bias, care must be taken to ensure a comprehensive evaluation that includes both psychotic and mood symptoms. Association With Suicidal Thoughts or Behavior 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 global dysfunction, including in social and occupational domains, 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 A wide variety of psychiatric and medical conditions can manifest with psychotic and mood symptoms and must be considered in the differential diagnosis of schizoaffective disorder. These include 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. 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. 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 major 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 only 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 4 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.) Achieving greater clarity about the relative proportion of mood to psychotic symptoms over time and about

their concurrence may require collateral information from medical records and from informants. 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, including metabolic syndrome, 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):
3. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to or withdrawal from a medication.
4. 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-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. In any case, an additional separate diagnosis of a substance use disorder is not given. 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 substanceinduced 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-10-CM With mild use disorder With moderate or severe use disorder Without use disorder Alcohol F10.159 F10.259 F10.959 Cannabis F12.159

F12.259 F12.959 Phencyclidine F16.159 F16.259 F16.959 Other hallucinogen F16.159 F16.259 F16.959 Inhalant F18.159 F18.259 F18.959 Sedative, hypnotic, or anxiolytic F13.159 F13.259 F13.959 Amphetamine-type substance (or other stimulant) F15.159 F15.259 F15.959 Cocaine F14.159 F14.259 F14.959 Other (or unknown) substance F19.159 F19.259 F19.959 Specify (see Table 1 in the chapter “Substance-Related and Addictive Disorders,” which indicates whether “with onset during intoxication” and/or “with onset during withdrawal” applies to a given substance class; or specify “with onset after medication use”): With onset during intoxication: If criteria are met for intoxication with the substance and the symptoms develop during intoxication. With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal. With onset after medication use: If symptoms developed at initiation of medication, with a change in use of medication, or during withdrawal of medication.

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 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 (or unknown) 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 same code should also 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 phencyclidineinduced 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 phencyclidineinduced 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 an independent 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 or withdrawal from a medication or after substance intoxication or withdrawal but can persist for weeks, whereas independent 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 an independent psychotic disorder (e.g., atypical age at onset or course). For example, the appearance of delusions de novo in a male person older than 35 years without a known history of an independent psychotic disorder should suggest the possibility of a substance/medication-induced psychotic disorder. Even a prior history of an independent 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 an independent 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 independent 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 nonsubstance/medication-induced psychotic disorders. In addition to the two symptom domain areas identified in the diagnostic criteria (i.e., delusions and hallucinations), 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 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-thecounter 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 psychotic symptoms 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. Alcoholinduced 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-type substances 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 longer. 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 amphetamine-type substances, 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. According to data from a Danish registry study that followed cases of substance-induced psychosis longitudinally over 20 years, roughly one-third (32%) of individuals with substanceinduced psychosis are later diagnosed with a schizophrenia spectrum disorder (26%) or a bipolar disorder (8%), with the highest rate (44%) for cannabis-induced psychotic disorder. 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 intoxication or substance withdrawal. Independent psychotic disorder. Psychotic disorder due to another medical condition. Other specified or unspecified schizophrenia spectrum and other psychotic disorder. Substance/medication-induced psychotic disorder is typically severely disabling and consequently is observed most frequently in emergency departments, 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 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. A substance/medication-induced psychotic disorder is distinguished from an independent 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. A substance/medication-induced psychotic disorder due to a prescribed treatment for a mental disorder 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 itself 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. The psychotic symptoms included in the diagnosis of substance/medication-induced psy-chotic disorder are limited to either delusions or hallucinations. Individuals with other

substance-induced psychotic symptoms (e.g., disorganized or catatonic behavior; disorganized speech; incoherence or irrational content) should be classified in the category other specified or unspecified schizophrenia spectrum and other psychotic disorder. 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: F06.2 With delusions: If delusions are the predominant symptom. 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., 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., C34.90 malignant lung neoplasm; 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, for example. 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. Although there are no infallible guidelines to determine whether the psychotic disturbance is etiologically attributable to another medical condition, three considerations can provide some guidance: biological plausibility, temporality, and typicality. First, the presence of a medical condition that has the potential to cause psychotic symptoms through a putative physiological mechanism (e.g., severe, generalized infection; porphyria; lupus; temporal lobe epilepsy) must be identified (biological plausibility). The second consideration is whether there is a temporal association between the onset, exacerbation, or remission of the medical condition and that of the psychotic disturbance (temporality). The third consideration in favor of a medical etiology of the psychotic symptoms is the presence of features that would be atypical for an independent psychotic disorder (e.g., atypical age at onset, presence of visual or olfactory hallucinations) (typicality). Finally, causes of psychotic symptoms other than the physiological effects of a medical condition need to be considered and ruled out (e.g., substance/medication-induced psychotic disorder, psychotic symptoms occurring as side effects of the treatment of the medical condition). 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. 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 wide variety of medical conditions may cause psychotic symptoms. These include neurological conditions (e.g., neoplasms, cerebrovascular disease, Huntington’s disease, Parkinson’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), vitamin B12 deficiency, fluid or electrolyte imbalances, hepatic or renal diseases, and autoimmune disorders with central nervous system involvement (e.g., systemic lupus erythematosus, N-methyl-D-aspartate [NMDA] receptor autoimmune encephalitis). The associated physical examination findings, laboratory findings, and patterns of prevalence or onset reflect the etiological medical condition. 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% in studies in Sweden and Finland. 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 in Finland. 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, NMDA receptor autoimmune encephalitis), or temporal lobe epilepsy. Psychosis attributable 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 individuals with epilepsy. Among older individuals, there may be a higher prevalence of the disorder in women, although additional sexor gender-related features are not clear and vary considerably with the sex and gender distributions of the underlying medical conditions. An estimated 60% of older individuals with new-onset psychosis have a medical etiology for their psychotic symptoms. 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 midlife, and older age groups more affected by a neurodegenerative disease (e.g., Alzheimer’s), 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

Course modifiers. Delirium and major or mild neurocognitive disorder. Substance/medication-induced psychotic disorder. Psychotic disorder. psychosis, possibly by serving to lower the threshold for experiencing psychosis. Risk and Prognostic Factors 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). Association With Suicidal Thoughts or Behavior 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 Hallucinations and delusions commonly occur in the context of a delirium; a separate diagnosis of psychotic disorder due to another medical condition is not given if the delusions and/or hallucinations occur exclusively during the course of a delirium. On the other hand, a diagnosis of psychotic disorder due to another medical condition may be given in addition to a diagnosis of major or mild neurocognitive disorder if the delusions or hallucinations are judged to be a physiological consequence of the pathological process causing the neurocognitive disorder (e.g., psychotic disorder due to Lewy body disease, with delusions). If there is evidence of recent or prolonged

substance use (including medications with psychoactive effects), withdrawal from a substance or medication that can cause psychotic symptoms on withdrawal, 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 due to another medical condition must be distinguished from a psychotic disorder that is not due to another medical condition (e.g., schizophrenia, delusional disorder, schizoaffective disorder) or a major 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. While certain symptoms suggest a medical or toxic etiology (e.g., visual or olfactory hallucinations, dreamlike quality of delusions [individual as uninvolved observer]), there are no pathognomonic signs or symptoms that unequivocally point clinicians either way. Visual hallucinations are not uncommon in schizophrenia or bipolar disorder, and olfactory hallucinations (e.g., unpleasant smells) are also consistent with a diagnosis of schizophrenia. Thus, clinicians should not give undue weight to any one particular hallucination alone when deciding between a psychiatric and a medical cause for psychopathology. Comorbidity Psychotic disorder due to another medical condition in individuals older than 80 years is associated with concurrent major neurocognitive disorder (dementia). Alzheimer’s disease is commonly accompanied by psychosis, and psychosis is a defining feature in Lewy body disease. Catatonia Catatonia can occur in the context of several disorders, including neurodevelopmental, psychotic, bipolar, and 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 3 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,

variable manifestations of the diagnosis, and overemphasis in teaching on rare, severe signs such as waxy flexibility 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, thromboembolism, pressure ulcers, muscle contractions, hyperpyrexia and self-inflicted injury. Catatonia Associated With Another Mental Disorder (Catatonia Specifier) 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., F06.1 catatonia associated with major depressive disorder). Code first the associated mental disorder (e.g., neurodevelopmental disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, or other mental disorder) (e.g., F25.1 schizoaffective disorder, depressive type; 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

F06.1 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. Meta-analysis of clinical samples indicated that approximately 9% of patients had catatonia. 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 G21.0 neuroleptic malignant syndrome. Culture-Related Diagnostic Issues The association between catatonia and mood disorders has been found in a wide range of cultural contexts. Catatonic Disorder Due to Another Medical Condition

Diagnostic Criteria 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. Coding note: Include the name of the medical condition in the name of the mental disorder (e.g., F06.1 catatonic disorder due to hepatic encephalopathy). The other medical condition should be coded and listed separately immediately before the catatonic disorder due to the medical condition (e.g., K72.90 hepatic encephalopathy; F06.1 catatonic disorder due to hepatic encephalopathy). Diagnostic Features The essential feature of catatonic disorder due to another medical condition is the presence of catatonia that is judged to be attributed to the physiological effects of another medical condition. Catatonia can be diagnosed by the presence of at least 3 of the 12 clinical features in Criterion A. There must be evidence from the history, physical examination, or laboratory findings that the catatonia is attributable to another medical condition (Criterion B). The diagnosis is not given if the catatonia is better explained by another mental disorder (e.g., manic episode) (Criterion C) or if it occurs exclusively during the course of a delirium (Criterion D). Associated Features A variety of medical conditions may cause catatonia, especially neurological conditions (e.g., neoplasms, head trauma, cerebrovascular disease, encephalitis) and metabolic conditions (e.g., hypercalcemia, hepatic encephalopathy, homocystinuria, diabetic ketoacidosis). The associated physical examination findings, laboratory findings, and patterns of prevalence and onset reflect those of the etiological medical condition. Differential Diagnosis A separate diagnosis of catatonic disorder due to another medical condition is not given if the catatonia occurs exclusively during the course of a delirium or neuroleptic malignant syndrome. However, even though a separate diagnosis of catatonia cannot be made, research suggests that catatonia symptoms occur in a significant proportion of delirium cases. If the individual is currently taking neuroleptic medication, consideration should be given to medication-induced movement disorders (e.g., abnormal positioning may be due to neuroleptic-induced acute dystonia) or neuroleptic malignant syndrome (e.g., catatonic-like features may be present, along with associated vital sign and/or laboratory abnormalities). Catatonic symptoms

may be present in any of the following five psychotic disorders: brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, and substance/medication-induced psychotic disorder. It may also be present in some of the neurodevelopmental disorders, in all of the bipolar and depressive disorders, and in other mental disorders.

Unspecified Catatonia This category applies to presentations in which symptoms characteristic of catatonia cause clinically significant distress or impairment in social, occupational, or other important areas of functioning but either the nature of the underlying mental disorder or other medical condition is unclear, full criteria for catatonia are not met, or there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Coding note: Code first R29.818 other symptoms involving nervous and musculoskeletal systems, followed by F06.1 unspecified catatonia. Other Specified Schizophrenia Spectrum and Other Psychotic Disorder F28 This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders diagnostic class. The other specified schizophrenia spectrum and other psychotic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific schizophrenia spectrum and other psychotic disorder. This is done by recording “other specified schizophrenia spectrum and other psychotic disorder” followed by the specific reason (e.g., “persistent auditory hallucinations”). Examples of presentations that can be specified using the “other specified” designation include the following:

1. Persistent auditory hallucinations occurring in the absence of any other features.
2. Delusions with significant overlapping mood episodes: This includes persistent delusions with periods of overlapping mood episodes that are present for a substantial portion of the delusional disturbance (such that the criterion stipulating only brief mood disturbance in delusional disorder is not met).
3. Attenuated psychosis syndrome: This syndrome is characterized by psychotic-like symptoms that are below a threshold for full psychosis (e.g., the symptoms are less severe and more transient, and insight is relatively maintained).
4. Delusional symptoms in the context of relationship with an individual with prominent delusions: In the context of a relationship, the delusional material from the individual with a psychotic disorder provides content for the same delusions held by the other person who may not otherwise have symptoms that meet criteria for a psychotic disorder. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder F29 This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders diagnostic class. The unspecified schizophrenia spectrum and other psychotic disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific schizophrenia spectrum and other psychotic disorder and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

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