

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 *erotomantic 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 same-culture 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 make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.

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. 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, mutism, 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 self-initiated 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 from positive stimuli or a degradation in the recollection of pleasure previously experienced. *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 another condition. In substance/medication-induced psychotic disorder, the psychotic symptoms are judged to be a 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. There is growing evidence that schizoaffective

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

Schizotypal (Personality) Disorder

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

Delusional Disorder

Diagnostic Criteria

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- A. The presence of one (or more) delusions with a duration of 1 month or longer.
- B. Criterion A for schizophrenia has never been met.

Note: Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).
- C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.
- D. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
- E. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

Specify whether:

Erotomaniac type: This subtype applies when the central theme of the delusion is that another person is in love with the individual.

Grandiose type: This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.

Jealous type: This subtype applies when the central theme of the individual's delusion is that his or her spouse or lover is unfaithful.

Persecutory type: This subtype applies when the central theme of the delusion involves the individual's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.

Somatic type: This subtype applies when the central theme of the delusion involves bodily functions or sensations.

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

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

Specify if:

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

Specify if:

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

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

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

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

Multiple episodes, currently in acute episode

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

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

Unspecified

Specify current severity:

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

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

Subtypes

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

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

Diagnostic Features

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

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

Associated Features Supporting Diagnosis

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

Prevalence

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

Development and Course

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

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

Culture-Related Diagnostic Issues

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

Functional Consequences of Delusional Disorder

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

Differential Diagnosis

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

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

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

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