schizophrenia and other psychotic disorders in *DSM-III*¹

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The authors are members of the Task Force on Nomenclature and Statistics of the American Psychiatric Association, as well as the Advisory Committee on Schizophrenic, Paranoid, and Affective Disorders. Other members of that committee who also participated in the preparation of drafts of these sections were Lyman C. Wynne, M.D., Robert Woodruff, M.D. (deceased), and Janet B.W. Forman, M.S.W. Many other members of the Task Force and of other Advisory Committees made valuable suggestions as did many of our colleagues not formally associated with this work.

The Third Edition of the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-III)* is expected to go into effect January, 1980. Work on this manual has been in progress since 1974. The sections describing Schizophrenia and related disorders have changed considerably over that time in order to reflect both new research findings and in response to feedback from the research community and clinicians using drafts of *DSM-III* in a series of field trials throughout the country. The purpose of this article is to describe the most recent approach to the definition of Schizophrenia and related disorders used in *DSM-III*, to delineate the issues involved, and to indicate the rationale behind the resolution of these issues.

The concept of Schizophrenia in *DSM-II* has been subdivided into a number of different categories in *DSM-III*. As a result, many individuals who would have been diagnosed as having Schizophrenia according to *DSM-II* would likely be diagnosed according to *DSM-III* as having either Paranoid Disorder, Schizoaffective Disorder, an Affective Disorder, Schizophreniform Disorder, Brief Reactive Psychosis, Atypical Psychosis, or Schizotypal Personality Disorder. The 1/15/78 definitions and criteria for Schizophrenia and these other disorders appear in the appendix (with the exception of Affective Disorders).

**Goals to be Achieved**

The definition of Schizophrenia in *DSM-III* was shaped by a number of different goals: to improve reliability, to reflect recent research findings, to relate diagnosis more closely to treatment and prognosis, to minimize the stigma of labeling, to achieve clinical acceptability in this country while at the same time reducing differences with our European colleagues, and, finally, to allow the clinician to express diagnostic uncertainty.

*Improve reliability.* It is well known that the interjudge reliability of the diagnosis of Schizophrenia by routine clinical evaluation has been low (Spitzer and Fleiss 1974). The impact of this on both clinical service and research has been adverse, to say the least. Since low reliability seriously reduces the opportunity for establishing the validity of a diagnostic cate-

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category, establishing adequate reliability is a goal of the highest priority.

Reflect recent research findings. Recent research findings bring into serious question the utility of the broad definition of Schizophrenia that has been characteristic of American diagnostic practices during the past two decades (Gurland et al. 1970). This research suggests that there are subgroups within the broad concept of Schizophrenia that have differential genetic, prognostic, and treatment correlates.

Relate to treatment and prognosis. One of the criticisms of the DSM-II concept of Schizophrenia was its limited relevance to treatment assignment and to the prediction of outcome. The definitions of categories in DSM-III have been written, whenever possible, to maximize this aspect of predictive validity.

Minimize labeling. Of all the diagnostic categories, perhaps Schizophrenia more than any other has been the focus of concern about the dangers of labeling and stigmatization (Mosher 1978). Although any diagnostic term has a potential for social abuse, there would seem to be advantages to defining the term as precisely and objectively as possible, while at the same time limiting the concept so that it is not applied to individuals who are likely to return to an adequate premorbid level of adjustment.

Achieve clinical acceptability. Although the membership of the Task Force and the various advisory committees is heavily represented by individuals who are academicians and researchers, DSM-III will primarily be used by clinicians, and therefore the approach to the diagnosis of Schizophrenia must be acceptable to them as well. In addition, from the viewpoint of comparative epidemiology, it would be extremely desirable if the concept were similar to that used by clinicians in other countries. The International Pilot Study of Schizophrenia has demonstrated that the diagnostic practices of American psychiatrists regarding Schizophrenia are aberrant from those of clinicians in other countries (World Health Organization 1973).

Express diagnostic uncertainty. In the real world of clinical practice, sometimes there is insufficient information to justify the diagnosis of a particular psychotic disorder. In the past, the DSM-II classification almost invariably forced clinicians to use the diagnosis of Schizophrenia for such cases. We believe it desirable to have a category that permits a clinician to indicate the presence of a psychotic disorder, without specifying the type, whenever inadequate information does not permit a more precise diagnosis.

Issues and Resolution

Diagnostic Criteria

As with the other categories in DSM-III, the descriptive material for Schizophrenia is followed by specific diagnostic criteria. There is evidence that the use of such criteria greatly improves the reliability of diagnostic judgments (Spitzer, Endicott, and Robins 1975). The criteria for Schizophrenia that are being used are a modification of the criteria used in the Research Diagnostic Criteria (Spitzer, Endicott, and Robins 1978). Kendell, Brockington, and Leff (1978) have compared the prognostic validity of the Research Diagnostic Criteria for Schizophrenia with the CATEGO program of Wing, Cooper, and Sartorius (1974), the Carpenter-Strauss Flexible System (Carpenter, Strauss, and Bartko 1973), the New Haven Index (Astrachan et al. 1972), and a clinical diagnosis made by the evaluator. When these diagnostic criteria were compared, the Research Diagnostic Criteria diagnosis of Schizophrenia was found to be the most predictive of both incomplete symptomatic recovery and poor social outcome.

Breadth of the Concept

The concept of Schizophrenia in DSM-II was very broad and explicitly included two nonpsychotic forms: Simple and Latent Schizophrenia. Although there is some research evidence suggesting a spectrum of Schizophrenia Disorders (Kety et al. 1978), the results of those studies are controversial (Gottesman and Shields 1976; Spitzer and Endicott, in press). Furthermore, in this instance other goals, such as the need to
relate diagnosis to treatment and outcome, argued for restricting the diagnosis to individuals who at some time in their lives have been psychotic. (By psychotic, we mean either delusions, hallucinations, or gross disorganization of speech or behavior.) Therefore, the DSM-III classification of Schizophrenia does not include either Latent, Simple, or Borderline Schizophrenia, and cases that would have been given these diagnoses according to DSM-II are likely to be given a diagnosis of Schizotypal Personality Disorder (Spitzer, Endicott, and Gibbon, in press).

Relationship to Affective Disorder

Ever since Kasanin (1933) coined the term Schizoaffective, there has been a controversy regarding the relationship between Affective Disorder and Schizophrenia. This controversy is part of the “good” versus “poor” prognosis controversy to be discussed below. Despite the difficulty in interpreting a muddled literature using either no or different criteria to define Schizoaffective, one consistent finding is a higher incidence of Affective Disorder among the relatives of such patients as compared with the relatives of patients given a diagnosis of Schizophrenia without affective disturbance (Clayton, Rodin, and Winokur 1971; Procci 1976; Vaillant 1962). Although originally the DSM-III classification of Schizophrenia included Schizoaffective as a subtype of Schizophrenia, as did DSM-II and does the International Classification of Diseases (ICD-9) (World Health Organization 1978), we decided to list it as a separate category. The definition of this category requires the presence of both the full affective syndrome and the characteristic symptoms of Schizophrenia. This is a compromise between two extremes: those who consider it a subtype of Schizophrenia and those who consider it a form of Affective Disorder (Pope and Lipinski 1978). We believe that the evidence is not yet in to resolve this controversy, and our decision permits the group to be studied without premature closure as to its relationship to Schizophrenia and Affective Disorder, as well as the possibility that it represents a third independent diagnostic class.

Phenomenology vs. Course

Many approaches to defining Schizophrenia limit the criteria to cross-sectional phenomenology without consideration of duration or the course of the illness. For example, Wing’s CATEGO program and Strauss and Carpenter’s Flexible System both make a diagnosis of Schizophrenia regardless of duration of symptoms. On the other hand, the Feighner criteria (Feighner et al. 1972) require a duration of 6 months, although it is not clear from the criteria whether the 6 months refer to active psychotic symptoms, failure to return to premorbid level of functioning, or prodromal symptoms. In addition, there are other approaches that stress the importance of insidious onset (Astrup and Noreik 1966).

After careful consideration, we chose to reject the use of cross-sectional phenomenology alone to make the diagnosis. Originally, we required (as did the Research Diagnostic Criteria) a minimum duration of 2 weeks to exclude the most transient psychotic disorders such as Brief Reactive Psychosis, often previously referred to as Hysterical Psychosis (Hollender and Hirsch 1964). Later we concluded that even with the 2-week duration we were combining within a single group both “good” and “poor” prognosis Schizophrenia. There is a vast literature indicating that these two groups differ markedly not only in prognosis, but also in family history, phenomenology, mode of onset, and perhaps treatment response (Fowler et al. 1972; McCabe et al. 1971; Stephens 1970; Vaillant 1964). At the present time, there is no entirely satisfactory method of separating these two groups on the basis of a cross-sectional evaluation. Some evidence suggests that requiring 6 months of symptoms is among the most powerful prognostic indicators (Astrup and Noreik 1966; Sartorius, Jablensky, and Shapiro 1978; Tsuang, Dempsey, and Rauscher 1976). For this reason, the criteria for the DSM-III diagnosis of Schizophrenia were changed to require
6 months' duration. It should be noted that the 6 months include prodromal and residual symptoms. Specific types of prodromal symptoms are noted within the criteria. Many of these prodromal symptoms, such as social isolation or withdrawal, impairment in personal hygiene and grooming, and markedly eccentric, odd, or peculiar behavior, have been enumerated in prognostic rating scales (Phillips 1953; Wittman 1941).

This decision has required the creation of a new diagnostic category for individuals whose clinical picture suggests Schizophrenia but whose duration of the illness has been less than 6 months and more than 1 week. We have named this category Schizophreniform Disorder, recognizing that our Scandinavian colleagues use the term in a similar but not identical manner (Strömgren 1965). For purposes of compatibility with ICD-9, this category has the same code number as Acute Schizophrenic Episode.

Kraepelin's original description of Dementia Praecox emphasized, as the name indicates, the tendency toward an early onset with a steady deterioration into a demented condition. Although the DSM-III criteria require a minimal degree of chronicity, there is no requirement that the course be a deteriorating one. In fact, the subtyping includes a category for "in remission" for those patients who recover from an episode of illness.

Pathognomonic Symptoms

According to Bleuler (1950), the fundamental disturbances in Schizophrenia (the "four A's") were present in each case and at every stage of the disease. In addition, the presence of any of these disturbances in their characteristic form was pathognomonic of the illness. According to Kurt Schneider (1959), certain symptoms are pathognomonic of Schizophrenia whenever organic illness can be excluded. Although both Bleuler and Schneider agree on the importance of pathognomonic symptoms for establishing the diagnosis, Bleuler emphasized underlying psychological processes that often require a high level of inference and were believed by him to reflect the fundamental disturbance of the illness, whereas Schneider's symptoms are more objective and have no theoretical or etiological significance.

We have concluded that the weight of the evidence rejects the utility of pathognomonic symptoms in establishing a diagnosis of Schizophrenia. Even when Bleulerian concepts, such as thought disorder or flatness of affect, are reliably defined using explicit behavioral descriptions, their differential diagnostic power is quite limited in separating what appears to be Schizophrenia from other disorders, particularly Affective Disorders (Andreasen, in press; Andreasen and Powers 1974). A series of studies has called into question the diagnostic specificity of Schneider's first rank symptoms (Carpenter and Strauss 1974; Carpenter, Strauss, and Muleh 1973; Taylor and Abrams 1973) although Wing and Nixon (1975) have questioned the adequacy of the data used in some of these studies. We have concluded that given our current knowledge (ignorance?), some of Schneider's first rank symptoms are useful in the diagnostic criteria, provided that both an Organic Mental Disorder and an affective syndrome have been ruled out.

None of the symptoms listed in the diagnostic criteria are considered pathognomonic. The symptoms that are listed include some Schneiderian first rank symptoms, other forms of hallucinations and delusions, and evidence of formal thought disorder if in combination with flat or inappropriate affect, delusions, hallucinations, or behavior that is grossly disorganized or catatonic. We have selected those symptoms that can be fairly reliably judged.

Relationship to Organic Mental Disorders

Some investigators believe that a Schizophrenic syndrome warrants a diagnosis of Schizophrenia even when there is a known organic etiology, such as amphetamine ingestion. We believe that whenever a potential etiologic factor can be identified, it should be reflected in the diagnosis. Thus, for us, a Schizophrenic-like picture due to a known organic factor is a dif-
ferent condition from what we mean by Schizophrenia and should be given a different name. (Such conditions are called either Organic Delusional Syndrome or Organic Hallucinosis in DSM-III.)

**Age at Onset**

The current criteria do not require an early age of onset. However, experience in the DSM-III field trials forced us to reconsider the question of the appropriateness of a diagnosis of Schizophrenia in an individual whose first episode of illness is diagnosed as Involutional Paraphrenia. Since it is likely that such conditions are fundamentally different from Schizophrenia of early onset, we believe it advisable to limit the diagnosis of Schizophrenia to individuals whose first episode of illness occurred before age 45. Individuals with later onset would receive the diagnosis of Atypical Psychosis. The next revision in the criteria will therefore exclude illnesses with onset after age 45.

**Impairment in Functioning**

Central to our concept of Schizophrenia is the notion that the disorder interferes with normal social and occupational functioning. Yet occasionally one encounters individuals with one or more of the characteristic Schizophrenic symptoms, such as bizarre delusions of long standing, without any apparent disruption of their functioning. We believe that in such problematic cases the diagnosis of Atypical Psychosis is preferable.

**Relationship to Paranoid Disorders**

Although DSM-II had a category of Paranoid States, the differential diagnosis of this category and Paranoid Schizophrenia was unclear. In DSM-III paranoid delusions, if not of a bizarre nature, or if not accompanied by hallucinations or formal thought disorder, do not warrant a diagnosis of Schizophrenia. Such cases would be diagnosed as either Paranoid Disorder or Atypical Psychosis. Paranoid Disorders are limited to conditions with prominent persecutory delusions or delusions of jealousy and exclude the presence of either prominent hallucinations or formal thought disorder.

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appendix

Schizophrenic Disorders

The essential features of this group of disorders\(^1\) are: disorganization of a previous level of functioning; characteristic symptoms involving multiple psychological processes; the presence of certain psychotic features during the active phase of the illness; the absence of a full affective syndrome concurrent with or developing before the active phase of the illness; a tendency toward chronicity; and the disturbance not being explainable by any of the Organic Mental Disorders.

As defined here, at some time during the illness a Schizophrenic Disorder always involves at least one of the following: delusions, hallucinations, or certain characteristic types of thought disorder. No single clinical feature is unique to this condition or evident in every case or at every phase of the illness, except that by definition the diagnosis is not made unless the period of illness has persisted for at least 6 months.

The limits of the concept of Schizophrenia are still unclear. Some approaches to defining the concept have emphasized the tendency toward a deteriorating course (Kraepelin), the presence of specific underlying disturbances in psychological processes (Bleuler), or pathognomonic symptoms or symptom complexes (Schneider). The approach taken here does not limit the concept to illnesses with a deteriorating course, although a minimal duration of illness is required because of the accumulated evidence which suggests that illnesses of briefer duration (here called Schizophreniform) are likely to have different correlates. The approach taken here also excludes illnesses without overt psychotic features, which have been referred to as latent, borderline, or simple schizophrenia. Such cases are likely to be diagnosed in this manual as having a Personality Disorder. Furthermore, individuals who develop either a depressive or manic syndrome before, or concurrent with, psychotic symptoms are not classified as having a Schizophrenic Disorder, but rather as having either an Affective or a Schizoaffective Disorder. Thus, this manual uses clinical criteria that include both a minimal degree of chronicity and a characteristic symptom picture, in an effort to identify a group of conditions that has validity in terms of differential response to somatic therapy, presence of a familial pattern, a tendency toward onset in early adult life, recurrence, and severe functional impairment.

Disorganization of a previous level of functioning.

\(^1\)Although this classification acknowledges that Schizophrenia is a group of disorders, common usage refers to Schizophrenia. Therefore, throughout this manual whenever the term Schizophrenia appears, it should be understood that conceptually the more accurate terminology would be Schizophrenic Disorders.
Schizophrenia always involves a disorganization of a previous level of functioning. Significant impairment always occurs in areas of routine daily functioning, such as work, social relations, and self-care. Family and friends often observe that the person is "no longer himself."

**Characteristic symptoms involving multiple psychological processes.** Invariably there are characteristic disturbances in several of the following areas: language and communication, content of thought, perception, affect, sense of self, volition, relationship to the external world, and motor behavior. It should be noted that no one of these features is invariably present or seen only in Schizophrenia.

A disturbance in language and communication is often present. This has been referred to as "formal thought disorder," or a disorder in form of thought, as distinguished from content of thought. As defined here, a language disorder involves the failure to follow semantic and syntactic rules, and is not attributable to lack of education, low intelligence, or cultural background. The most common example of this is incoherence, in which statements are incomprehensible. A rare form of language disorder in Schizophrenia is neologism. Communication disorders are here defined as disturbances of speech or writing such that there is an obstacle to the understanding of the message by a listener or reader. This is due to deviations in rate, content, or form, and is not explainable by a language disorder, intellectual defect, or cultural background. The common communication disorders in Schizophrenia are derailment, poverty of content of speech, and illogicality. In derailment (loosening of associations), ideas slip off one track onto another one that is clearly but obliquely related, or onto one that is completely unrelated. Things may be said in juxtaposition which lack a meaningful relationship, or the individual may shift idiosyncratically from one frame of reference to another. In poverty of content of speech, the speech is adequate in amount but conveys little information because it is vague, overabstract or overconcrete, repetitive, or stereotyped. The listener may recognize this disturbance by noting that little if any information has been conveyed although the individual has spoken at some length. In illogicality, apart from delusional thinking that may be present, facts are obscured, distorted, or excluded, and conclusions are arrived at on the basis of inadequate or faulty evidence. Less common communication disorders in Schizophrenia include perseveration and blocking.

**Content of thought.** The major disturbance in the content of thought involves delusions, which often are multiple, fragmented, and bizarre. However, simple persecutory delusions involving the belief that others are spying on, spreading false rumors about, or planning harm to the individual are common. Delusions of reference, in which unrelated events are given personal significance, are also common. For example, a newspaper article or television program may be interpreted as giving a special personal message, usually of a negative or perjorative nature. Certain delusions appear to be very characteristic of this disorder. These include, for instance, the belief or experience that an individual's thoughts, as they occur, are broadcast from his head into the external world so that others can hear them (thought broadcasting); that thoughts, which are not his own, are inserted into his mind (thought insertion); that thoughts have been removed from his head (thought withdrawal); or that his feelings, impulses, thoughts, or actions are not his own and are imposed upon him by some external force (delusions of being controlled or delusions of passivity). Less commonly, somatic, grandiose, religious, and nihilistic delusions are seen. Overvalued ideas may occur, such as preoccupation with the special significance of particular dietary habits.

**Perception.** The major disturbances in perception are various forms of hallucinations. Although they may occur in all modalities, by far the most common are auditory hallucinations, frequently involving voices heard from outside of the head. The voices may be familiar, may be responded to, and commonly make insulting statements. The voices may be solitary or multiple. Voices speaking directly to the individual or commenting on his ongoing behavior are particularly characteristic. Occasionally the auditory hallucinations are of sounds rather than voices. Tactile (haptic) hallucinations may be present and typically involve electrical, tingling, or burning sensations. Somatic hallucinations, such as the sensation of snakes crawling inside the abdomen, are occasionally present. Visual, gustatory, and olfactory hallucinations also occur, but with less frequency, and should always raise the question of the possible presence of an Organic Mental Disorder.

**Affect.** The disturbance in affective expression often involves blunting or flattening or inappropriateness of affect. In blunted affect there is a severe reduction in the intensity of affective expression. In flat affect there are virtually no signs of affective expression. In such instances, the voice may be monotonous and the face immobile. The individual...
may complain that he no longer responds emotionally with his normal intensity or, in extreme cases, that he no longer has any feelings at all. Affect is inappropriate when it is clearly discordant with the content of the individual's speech or ideation. For example, while discussing how he is being tortured by electrical shocks administered by his persecutors, an individual with Paranoid Schizophrenia may laugh or smile. Sudden and unpredictable changes in affect, which may involve inexplicable outbursts of anger, may occur.

Unfortunately, despite the importance of affective disturbance in Schizophrenia, its usefulness in making the diagnosis is limited because the judgment of it is often unreliable except when it is present in an extreme form. Furthermore, the antipsychotic drugs can produce a state that is nearly identical to the affective flattening seen in Schizophrenia.

**Sense of self.** The sense of self that gives the normal person his feeling of individuality, uniqueness, and self-direction is frequently disturbed. This is sometimes referred to as a loss of ego boundaries and may manifest itself in morbid perplexity about one's own identity and the meaning of existence, or in some of the specific delusions described above, particularly those involving control by some outside forces.

**Volition.** Nearly always there is some disturbance in self-initiated goal-directed activity, which may grossly impair work or other role functioning. It may take the form of inadequate interest or drive, or inability to complete successfully a course of action. Pronounced ambivalence regarding two opposite courses of action may lead to near cessation of goal-directed activity. Antipsychotic medication may produce akinesia, which often appears nearly identical to a disturbance in volition. Antipsychotic medication may also produce sedation, which does cause a disturbance in volition.

**Relationship to the external world.** Frequently there is a tendency to withdraw from involvement with the external world and to become preoccupied with ideas and fantasies that are egocentric and illogical, and in which objective facts then tend to be obscured, distorted, or excluded. Severe forms of this are referred to as autism. Family members or friends may comment that the individual seems preoccupied, in his own world, and emotionally detached from others.

**Motor behavior.** Various disturbances in motor behavior may be seen, particularly in the severe and chronic or more acutely florid forms of Schizophrenia. There may be a marked decrease in reactivity to the environment, with a reduction of spontaneous movements and activity, and the individual may appear to be unaware of the nature of his surroundings (as in catatonic stupor). The individual may maintain a rigid posture against any efforts to move him (as in catatonic rigidity). There may be apparently purposeless and stereotyped excited motor activity not influenced by external stimuli (as in catatonic excitement). The individual may voluntarily assume inappropriate or bizarre postures (as in catatonic posturing). The individual may resist and actively counteract instructions or attempts to move him (catatonic negativism). In addition, there may be mannerisms, grimacing, or waxy flexibility.

**Associated features.** Almost any psychiatric symptom can occur as an associated feature. The individual may appear perplexed, disheveled, or eccentrically groomed or dressed. Abnormalities of psychomotor activity are common with either pacing, rocking, or apathetic immobility. Ritualistic or stereotyped behavior which may be associated with magical thinking may occur. Dysphoric mood is common; it may take the form of depression, anxiety, anger, or a mixture of these. Depersonalization, derealization, simple ideas of reference, and illusions are commonly present, as are hypochondriacal concerns that may or may not be delusional. Typically there is no disturbance in sensorium, although during a period of exacerbation, the individual may be confused, perplexed and even disoriented, or show impairment in memory.

**Age at onset.** Onset is usually during adolescence or early adult life. Rarely, it may be in childhood or middle or late adult life.

**Course.** As noted previously, the diagnosis of Schizophrenia requires that continuous signs of the illness have lasted for at least 6 months during the person's life. The 6-month period must include an active phase of psychotic symptoms, with or without a prodromal or residual phase.

A **prodromal phase** occurs frequently. That is, before the development of the active phase of the illness there is a clear deterioration in functioning with such symptoms as social isolation or withdrawal, impairment in role functioning, eccentric, odd, or peculiar behavior, impairment in personal hygiene and grooming, blunted or inappropriate affect, disturbances in communication, odd or bizarre ideation, and unusual perceptual experiences. A change in personality may be noted by friends or relatives. The length of this prodromal phase is extremely variable, and its onset may be difficult to date accurately. In those cases in which the prodromal
phase is characterized by an insidious downhill course over many years, the prognosis is especially poor.

During the active phase there are prominent psychotic symptoms, such as delusions, hallucinations, derailment (loosening of associations), incoherence, poverty of content of speech, illogicality, and behavior that is grossly disorganized or catatonic. The specific psychotic symptoms, at least one of which is necessary to make the diagnosis, are noted in criterion A of the diagnostic criteria (p. 500). The onset of the active phase, either initially or as an exacerbation, is frequently associated with the occurrence of a psychosocial stressor. In such cases, the severity of the psychosocial stressor should be noted on Axis IV.

Usually a residual phase follows the active phase of the illness. The clinical picture of this phase is similar to that seen in the prodromal phase, although affective blunting or flattening and impairment in role functioning tend to be more common. During the residual phase some of the psychotic symptoms, such as delusions or hallucinations, may persist but have lost their affective coloring.

A complete return to premorbid functioning is unusual. In fact, some clinicians would question the diagnosis under such circumstances. However, the concept of Schizophrenia used here does not exclude the possibility of full remission or recovery, but the frequency of this course is unknown. There is a strong tendency for acute exacerbations requiring therapeutic intervention, usually with increasing residual impairment between episodes.

Numerous studies have indicated a group of factors that are associated with a good prognosis: good premorbid personality with adequate social functioning, the presence of precipitating events, abrupt onset, onset late in life, a clinical picture that involves confusion or perplexity, and a family history of Affective Disorder.

Because a knowledge of course is of such importance for planning treatment, and because differences in course may reflect fundamental differences in subgroups of the Schizophrenic Disorders, course is coded in the fifth digit. The course has been operationally divided into subchronic, chronic, subchronic with acute exacerbation, chronic with acute exacerbation, and in remission. For the definitions of these categories, see diagnostic criteria on p. 503.

Since a 6-month duration of illness is required for a diagnosis of Schizophrenia, there is no acute subtype. The diagnosis of Schizophreniform Disorder is the nearest equivalent to the DSM-II and ICD-9-CM concepts of Acute Schizophrenic Episode. Frequently, an episode of Schizophreniform Disorder will persist for more than 6 months, requiring a change of diagnosis to Schizophrenia.

Impairment. During the active phase of the illness, the psychotic symptoms are associated with significant impairment in several areas of routine daily functioning, such as work, social relations, or self-care. The person may require supervision to ensure that his biological needs are met and that he is protected from the consequences of his poor judgment, cognitive impairment, or acting on the basis of his delusional beliefs. Following an initial episode, and between subsequent exacerbations, the degree of disability can vary widely. Some individuals have virtually none, whereas others are severely impaired and may require prolonged institutional care.

Complications. The illness is so pervasive that it is difficult to separate the complications from the manifestations of the impairment. Complications include failure of educational achievement, work performance below that appropriate to education, social isolation, and inability to develop or maintain close interpersonal relationships. Although violent acts performed by individuals with this disorder may achieve notoriety, it is not known whether the incidence of violent acts is higher than in the nonschizophrenic population. The life expectancy is shorter than that of the general population due to an increased suicide rate and death from a variety of other causes, some of which have, at least previously, been associated with institutional care. Others are probably associated with the economically deprived environments in which many individuals with these disorders live.

Premorbid personality. The personalities of individuals who later develop Schizophrenia are often described as suspicious, introverted, withdrawn, or eccentric. Such individuals may meet the criteria for Paranoid, Introverted, Schizotypal, or Borderline Personality Disorder. In such cases, the premorbid Personality Disorder should be noted on Axis II since it may have prognostic significance.

Predisposing factors. The diagnosis is made more commonly among the lower socioeconomic groups. The reasons for this are still under investigation, but downward social drift and increased stress are likely contributors.

Various specific patterns of family interaction have been posited as being of etiological significance in the development of the illness. None of the various hypotheses have as yet been confirmed.

Prevalence. Many studies done in Europe and
Asia have reported that a sizable proportion of members of a population alive at any given moment have had at some time in their lives an episode of a disorder that research workers in these areas have called Schizophrenia, using a relatively narrow concept of the disorder. The proportion has ranged from approximately .2 percent to almost 1 percent. In every location where these studies have been done, the cases designated as Schizophrenia constitute a sizable proportion of all psychoses. Some studies done in the United States, which have used broader criteria and surveyed urban populations, have reported higher rates.

Sex ratio. The disorder is apparently equally common in males and females.

Familial pattern. All investigators have found a higher prevalence of the disorder among biologically related family members. This includes studies in which the adopted offspring of individuals with Schizophrenia have been reared by normal parents. Twin studies consistently show a higher concordance rate for monozygotic twins than dizygotic twins, while dizygotic twins have the same concordance rate as nontwin siblings. However, being a monozygotic twin does not in itself predispose to the development of a Schizophrenic Disorder. Although genetic factors have been proven to be involved in the development of the illness, the relatively low concordance rate even in monozygotic twins indicates the importance of nongenetic factors.

Differential diagnosis. Organic Mental Disorders often present with symptoms that suggest Schizophrenia, such as delusions, hallucinations, incoherence, and blunted or inappropriate affect. In particular, Organic Delusional Syndromes, such as associated with amphetamines or phencyclidine, may cross-sectionally be identical in phenomenology to Schizophrenia. Even though an exacerbation of Schizophrenia may be associated with confusion, the presence of disorientation or memory impairment strongly suggests an Organic Mental Disorder. The diagnosis of Schizophrenia should not be made until the evidence indicates that the episode of illness is not due to any of the Organic Mental Disorders. This does not mean that Organic Mental Disorders and Schizophrenia as two separate disorders may not coexist in the same individual.

Paranoid Disorders are distinguished from Schizophrenia by the absence of prominent hallucinations, incoherence, derailment (loosening of associations), or those delusions listed in criterion A of the diagnostic criteria for Schizophrenia (see p. 500), such as delusions of being controlled or thought broad-casting.

In Schizoaffective and Affective Disorders, there is always a full affective syndrome, and it either precedes or develops concurrently with any psychotic symptoms that may be present. In Schizophrenia, by definition, if an affective syndrome develops at all, it occurs after the development of the psychotic symptoms. The differential diagnosis from psychotic forms of the Affective Disorders, particularly mania, is of special importance because of the different treatment implications.

Atypical Depressive Disorder or Adjustment Disorder With Depressed Mood may be superimposed on Residual Schizophrenia, providing that there is no exacerbation of the psychotic Schizophrenic symptoms. In such instances, both diagnoses should be made.

In Schizophreniform Disorder, by definition, the duration of the illness is less than 6 months. The cross-sectional symptom picture may be indistinguishable from Schizophrenia although emotional turmoil and confusion are more likely in Schizophreniform Disorder. It should be noted that the 6-month duration of illness required for Schizophrenia refers to a continuous period of illness. Thus, an individual with several episodes of Schizophreniform Disorder from which there was always a full recovery would not be diagnosed as having Schizophrenia merely because the total period of illness exceeded 6 months. Often it is difficult to determine the duration of illness required to make the differential between Schizophreniform Disorder and Schizophrenia.

Atypical Psychosis should be diagnosed in those unusual instances in which some of the characteristic Schizophrenic psychotic symptoms are present but without any impairment in routine daily functioning. An example is an encapsulated delusion of bodily change.

In Obsessive Compulsive Disorder, and more rarely, Phobic Disorder, the individual occasionally develops explanatory ideas to account for his symptoms that are difficult to distinguish from delusions. However, the individual with Obsessive Compulsive or a Phobic Disorder recognizes that his symptoms and thinking are irrational, even when dominated by them.

In Factitious Illness With Psychological Symptoms, any seemingly psychotic symptoms are under the individual's voluntary control and are likely to be present only when the individual thinks he is being observed.

In Atypical Somatoform Disorder the individual may have chronic hypochondriacal concerns that
may be difficult to distinguish from somatic delusions.

In severe Personality Disorders, transient psychotic symptoms may occur. However, a quick return to the usual level of functioning distinguishes this exacerbation from Schizophrenia. The more difficult differential is to distinguish severe forms of Paranoid and Schizotypal Personality Disorders from Schizophrenia because of the difficulty in determining whether the paranoid ideation is of delusional intensity and whether the oddities of communication and perception are severe enough to meet the criteria for Schizophrenia. Furthermore, it is often difficult to differentiate the prodromal phase of Schizophrenia from the manifestations of some of the Personality Disorders, since both Personality Disorders and Schizophrenia usually develop during adolescence or early adult life.

Individuals who are members of religious or other subcultural groups may have beliefs or experiences that are difficult to distinguish from pathological delusions or hallucinations. When such experiences are explainable by identification with such subcultural groups or values, they should not be considered evidence of Schizophrenia. Useful clues that such experiences should not be considered pathological include the occurrence of the experiences during religious ceremonies or in other religious contexts, and the acceptance by the subgroup and the individual himself of the behavior as normal or desirable.

In Mental Retardation, the low level of social functioning, the oddities of behavior, and the impoverished affect and cognition all may suggest a chronic form of Schizophrenia. Both diagnoses in the same individual should be made only when there is certainty that the symptoms suggesting Schizophrenia, such as delusions or hallucinations, are definitely present and not the result of difficulties in communication.

No Mental Disorder is difficult to distinguish from Schizophrenia in Remission. Guidelines are suggested in the diagnostic criteria for classification of the disorder on p. 503.

Diagnostic Criteria for a Schizophrenic Disorder

Characteristic Schizophrenic Symptoms

A. At least one symptom from any of the following 10 symptoms was present during an active phase of the illness (because a single symptom is given such diagnostic significance, its presence should be clearly established):

Characteristic Delusions

1. Delusions of being controlled: Experiences his thoughts, actions, or feelings as imposed on him by some external force.
2. Thought broadcasting: Experiences his thoughts, as they occur, as being broadcast from his head into the external world so that others can hear them.
3. Thought insertion: Experiences thoughts, which are not his own, being inserted into his mind (other than by God).
4. Thought withdrawal: Belief that thoughts have been removed from his head, resulting in a diminished number of thoughts remaining.
5. Other bizarre delusions (patently absurd, fantastic, or implausible).
6. Somatic, grandiose, religious, nihilistic, or other delusions without persecutory or jealous content.
7. Delusions of any type if accompanied by hallucinations of any type.

Characteristic Hallucinations

8. Auditory hallucinations in which either a voice keeps up a running commentary on the individual's behaviors or thoughts as they occur, or two or more voices converse with each other.
9. Auditory hallucinations on several occasions with content having no apparent relation to depression or elation, and not limited to one or two words.

Other Characteristic Symptoms

10. Either incoherence, derailment (loosening of associations), marked illogicality, or marked poverty of content of speech—if accompanied by either blunted, flat, or inappropriate affect, delusions or hallucinations, or behavior that is grossly disorganized or catatonic.

Impairment in Daily Functioning

B. During the active phase of the illness, the symptoms in A have been associated with significant impairment in two or more areas of routine daily functioning (e.g., work, social relations, self-care).
Chronicity

C. Signs of the illness have lasted continuously for at least 6 months at some time during the person's life, and the individual now has some signs of the illness. The 6-month period must include an active phase during which there were symptoms from A with or without a prodromal or residual phase, as defined below.

Prodromal Phase

A clear deterioration in functioning not due to a primary disturbance in mood or to substance abuse, and involving at least two of the symptoms noted below.

Residual Phase

Following the active phase of the illness, at least two of the symptoms noted below, not due to a primary disturbance in mood or to substance abuse.

Prodromal or Residual Symptoms

(1) Social isolation or withdrawal.
(2) Marked impairment in role functioning as wage-earner, student, homemaker.
(3) Markedly eccentric, odd, or peculiar behavior (e.g., collecting garbage, talking to self in corn field or subway, hoarding food).
(4) Impairment in personal hygiene and grooming.
(5) Blunted, flat, or inappropriate affect.
(6) Speech that is tangential, digressive, vague, overelaborate, circumstantial, or metaphorical.
(7) Odd or bizarre ideation, or magical thinking, e.g., superstitiousness, clairvoyance, telepathy, "sixth sense," "others can feel my feelings," over-valued ideas, ideas of reference, or suspected delusions.
(8) Unusual perceptual experiences, e.g., recurrent illusions, sensing the presence of a force or person not actually present, suspected hallucinations.

Examples. Six months of prodromal symptoms with 1 week of symptoms from A; no prodromal symptoms with 6 months of symptoms from A; no prodromal symptoms with 2 weeks of symptoms from A and 6 months of residual symptoms; 6 months of symptoms from A, apparently followed by several years of complete remission, with 1 week of symptoms in A in current episode.

Full Affective Syndrome Absent

D. The full depressive or manic syndrome (criteria A and B of Depressive or Manic Episode) is either not present or, if present, developed after any psychotic symptoms.

No Organic Mental Disorder

E. The symptoms observed are not due to any organic mental disorder.

Phenomenological Subtypes

The phenomenological subtypes are subcategorized to reflect the major cross-sectional clinical syndromes despite the knowledge that some are less stable over time than others and that their prognostic and treatment implications are variable. Changes in the phenomenological subtypes should not be made unless the shift in the predominant clinical picture persists for more than several weeks.

295.1x Disorganized (Hebephrenic)

The essential features are marked incoherence and affect that is flat, incongruous, or silly. Fragmentary delusions or hallucinations with the content not organized into a coherent theme are common associated features.

Other associated features include grimaces, mannerisms, hypochondriacal complaints, extreme social withdrawal, and other oddities of behavior.

This clinical picture is usually associated with poor premorbid personality, an early and insidious onset, and a chronic course without significant remissions. Social impairment is usually extreme.

Diagnostic Criteria for Disorganized Subtype

A. Meets the criteria for Schizophrenia.
B. Frequent or constant incoherence.
C. Affect is flat, incongruous, or silly.

295.2x Catatonic

The essential feature is a marked psychomotor disturbance that may involve particular forms of stupor, rigidity, excitement, or posturing. Some-
times there is a rapid alternation between the extremes of excitement and stupor. Associated features include negativism, stereotypes, mannerisms, and waxy flexibility. Mutism is particularly common.

During catatonic stupor or excitement the individual needs careful supervision, and his illness may constitute a medical emergency because of the risks of starvation, exhaustion, hyperpyrexia, or inflicting injury on himself or others.

This subtype was once among the most common. It is now rare in Europe and North America.

**Diagnostic Criteria for Catatonic Subtype**

A. Meets the criteria for Schizophrenia.
B. Throughout the active period of the current episode of illness the clinical picture is dominated by any of the following catatonic symptoms:
   1. Catatonic stupor or mutism (marked decrease in reactivity to environment and/or reduction of spontaneous movements and activity).
   2. Catatonic rigidity (maintains a rigid posture against efforts to move him).
   3. Catatonic excitement (apparently purposeless and stereotyped excited motor activity, not influenced by external stimuli).
   4. Catatonic posturing (voluntary assumption of inappropriate or bizarre posture).

295.3x Paranoid

The essential feature is a clinical picture dominated by the relative persistence of, or preoccupation with, persecutory or grandiose delusions, or hallucinations with a persecutory or grandiose content. In addition, there may be delusions of jealousy.

Associated features include anger, argumentativeness, violence, fearfulness, delusions of reference, and concerns about autonomy, gender identity, and sexual preference. The impairment in functioning may be minimal if the delusional material is not acted upon, since gross disorganization of behavior is relatively rare. Likewise, affective responsiveness may be preserved. Often there is either a stilted, formal quality, or an extreme intenseness to interpersonal interactions.

The onset tends to be later in life than the other subtypes. As a subtype, it is more stable over time than the other subtypes. There is some evidence that if a relative of an individual with Paranoid Schizophrenia has Schizophrenia, it is likely that the subtype will also be Paranoid.

**Diagnostic Criteria for Paranoid Subtype**

A. Meets the criteria for Schizophrenia.
B. Throughout the active period of the current episode of illness, the clinical picture is dominated by the relative persistence of, or preoccupation with, one or more of the following:
   1. Persecutory delusions.
   2. Grandiose delusions.
   3. Delusions of jealousy.
   4. Hallucinations with a persecutory or grandiose content.

295.9x Undifferentiated

This category should be used when the episode of illness is characterized by prominent psychotic symptoms that cannot be classified in any category previously listed, or that meet the criteria for more than one.

**Diagnostic Criteria for Undifferentiated Subtype**

A. Meets the criteria for Schizophrenia.
B. Psychotic symptoms are prominent delusions, hallucinations, incoherence, derailment (loosening of associations), grossly disorganized behavior.
C. Does not meet the criteria for any of the previously listed specific active subtypes, or meets the criteria for more than one.

295.6x Residual

This category should be applied to an individual who has had an episode of illness that met the criteria for Schizophrenia. Although the clinical picture now does not contain any prominent psychotic symptoms, signs of the illness persist. Emotional blunting, social withdrawal, eccentric behavior, and mild communication disorder are common. Delusions or hallucinations may be present but have lost their affective coloring.

Conceptually, this category is equivalent to the category of In Partial Remission specified under the severity subtypes of some of the Affective Disorders.

**Diagnostic Criteria for Residual Subtype**

A. Once had an episode of Schizophrenia with one or more psychotic symptoms (delusions, hallucina-
tions, incoherence, grossly bizarre behavior).
B. Current clinical picture does not contain any prominent psychotic symptoms.
C. Still shows signs of the illness, such as blunted or inappropriate affect, social withdrawal, eccentric behavior, or some evidence of communication disorder.

Classification of Course

The course of the illness is noted in the fifth digit.
(1) Subchronic. The length of time from the beginning of the active phase of the illness, during which the individual more or less continuously showed signs of the prodromal, active, or residual phases of the illness, is less than 2 years but at least 6 months.
(2) Chronic. Same as above but greater than 2 years.
(3) Subchronic with acute exacerbation. The reemergence of prominent psychotic symptoms in an individual with a subchronic course who has been in the residual phase of the illness.
(4) Chronic with acute exacerbation. The reemergence of prominent psychotic symptoms in an individual with a chronic course who has been in the residual phase of the illness.
(5) In remission. This should be used when the individual met the full criteria for Schizophrenia in the past and now is free of all clinical signs of the illness (whether or not on medication). The differentiation of Schizophrenic Disorder in Remission from No Mental Disorder requires consideration of the period of time since the last episode, the number of episodes, and the need for continued evaluation or prophylactic treatment. However, it is recommended that when an individual is in a state of full remission without medication for 5 years or more, the diagnosis should be changed to No Mental Disorder (unless there is some other disorder).

When the course is noted as In Remission, the phenomenologic subtype should describe the phenomenology of the last episode of schizophrenic illness. When the phenomenology of the last episode is unknown, it should be noted as Undifferentiated.

Paranoid Disorders

The essential feature is a clinical picture in which the predominant symptoms are persistent persecutory delusions or delusions of jealousy, not explainable by either a Schizophrenic, Schizophreniform, Schizoaffective or Affective Disorder, Brief Reactive Psychosis, or Organic Mental Disorder. The Paranoid Disorders include Paranoia, Shared Paranoic Disorder, and Paranoid State.

The boundaries of this group of disorders and their differentiation from other disorders, particularly severe Paranoid Personality Disorder and Paranoid Schizophrenia, are unclear.

The persecutory delusions may be simple or elaborate, and usually involve a single theme or series of connected themes, such as being conspired against, cheated, spied upon, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals. Small slights may be exaggerated and form the nucleus of a delusional system.

Delusions of jealousy, often referred to as conjugal paranoia, are common without any clear persecutory theme. On the basis of no or irrelevant evidence, a spouse will become convinced that his or her mate is unfaithful. Small bits of "evidence," such as disarrayed clothing or spots on the sheets, will be collected and used to justify the delusion.

Associated features. Common associated features include anger and resentment, which may lead to violence. Ideas or delusions of reference are common. Often there is social isolation, exclusiveness, or eccentricities of behavior. Suspiciousness, either generalized or focused on certain individuals, is common. Letter writing, complaining about various injustices, as well as the instigation of legal action, are often seen.

Predisposing factors. There is some evidence that immigration, migration, deafness, and other stresses may predispose to the development of a Paranoid Disorder. There is also some evidence that individuals with Paranoid or Schizoid Personality Disorders have a greater likelihood of developing one of the Paranoid Disorders.

Course, impairment, age at onset. There is rarely impairment in daily functioning. In contrast to Schizophrenia, intellectual and occupational functioning are usually relatively well preserved even in chronic forms of Paranoid Disorder. Social and marital functioning, on the other hand, are often
severely impaired. These individuals rarely seek treatment on their own and frequently are brought for care by associates, relatives, or governmental agencies as a result of their angry or litigious activities. The age at onset is generally later than that of Schizophrenia.

Sex ratio and familial pattern. No information.

Prevalence. This group of disorders is apparently rare. One study, using criteria for paranoid disorders similar to those of this manual, indicated that, of a large number of psychiatric hospital admissions, only from .1 to .4 percent met the criteria.

Differential diagnosis. In Organic Delusional Syndromes, particularly those induced by amphetamines, paranoid delusions may be particularly prominent.

In Paranoid Schizophrenia there are characteristic schizophrenic symptoms, such as incoherence, derailment (loosening of associations), prominent hallucinations, delusions of control, thought broadcasting, withdrawal or insertion. Although delusions that others are attempting to control the individual's behavior are common in both Paranoid and Schizophrenic Disorders, the experience of being controlled by alien forces is indicative of Schizophrenia or Schizophreniform Disorders. In addition, Schizophrenic delusions are more likely to be bizarre, fragmented, and multiple.

In Paranoid Personality Disorder there are no frank paranoid delusions or delusions of jealousy.

**Diagnostic Criteria for Paranoid Disorders**

A. Persistent persecutory delusions or delusions of jealousy are the predominant clinical feature.
B. Does not have any of the characteristic schizophrenic symptoms (criterion A of Schizophrenia, see p. 500).
C. The absence of the manic or depressive syndrome as noted in criteria A and B of the diagnostic criteria for Manic and Depressive Episodes.
D. Duration of illness at least 1 week from onset of a noticeable change in the individual's usual condition.
E. Not due to any Organic Mental Disorder.

**297.10 Paranoia**

The essential feature is an insidious development of a permanent and unshakeable delusional system accompanied by preservation of clear and orderly thinking. Emotion and behavior are consistent with the delusional system. Frequently the individual considers himself endowed with unique and superior ability. Chronic forms of conjugal paranoia should be classified here.

**Diagnostic Criteria for Paranoia**

A. Meets the criteria for Paranoid Disorder.
B. Insidious development of a chronic and unshakeable paranoid delusional system.
C. Preservation of clear and orderly thinking.
D. Emotion and behavior are consistent with the delusional system.

**297.30 Shared Paranoid Disorder (Folie à Deux)**

The essential feature is a paranoid delusional system that develops as a result of a close relationship with another person who already has an established paranoid psychosis. The delusions are at least partly shared. Usually if the individual can be separated from the other person, the delusional beliefs will diminish or disappear. In the past this condition has been termed folie à deux. In rare cases, more than two persons may be involved.

**Diagnostic Criteria for Shared Paranoid Disorder**

A. Meets the criteria for Paranoid Disorder.
B. Delusional system develops as a result of a close relationship with another person who already has an established paranoid psychosis.

**297.90 Paranoid State**

This is a residual category for Paranoid Disorders not classified above. The most common form is seen in individuals who have recently changed their living or work situation, such as immigrants, refugees, prisoners of war, inductees into the military services, or young people leaving home for the first time. The onset is usually relatively sudden, and the condition rarely becomes chronic.

**Diagnostic Criteria for Paranoid State**

A. Meets the criteria for Paranoid Disorder.
B. Does not meet the criteria for either Paranoia or Shared Paranoid Disorder.

Schizoaffective Disorders

The essential features are: a depressive or manic syndrome of at least 1 week's duration that precedes or develops concurrently with certain psychotic symptoms thought to be incompatible with a purely affective disorder; the diagnosis is not made if the disturbance is due to any Organic Mental Disorder.

In other classification systems, Schizoaffective is a subtype of Schizophrenia. In this manual, Schizoaffective Disorders are being listed separately because of the accumulated evidence that individuals with a mixture of "affective" and "schizophrenic" symptoms (as compared with individuals diagnosed as having Schizophrenia as defined in this manual) are characterized by a better prognosis, a tendency toward acute onset and resolution, a more likely recovery to premorbid level of functioning, and an absence of an increase in the prevalence of Schizophrenia among family members as compared with the general population. Furthermore, there is an increase in the prevalence of Affective Disorders among family members.

At the present time there is controversy as to whether this disorder represents a variant of Affective Disorder or Schizophrenia, a third independent nosological entity, or part of a continuum between pure Affective Disorder and pure Schizophrenia.

The term "Schizoaffective" has historically been used in many different ways. Here an essential requirement is that the affective syndrome must precede or develop concurrently with the psychotic symptoms. The development of a full affective syndrome following an established psychotic syndrome is excluded from this category because affective symptomatology following the development of a psychotic syndrome is very common, and does not appear to have the same significance as affective symptoms that precede or develop concurrently with a psychotic syndrome.

The psychotic symptoms that are used to make the diagnosis of Schizoaffective Disorder are of two kinds. The first are symptoms that are part of the list of criteria for Schizophrenia, such as delusions of control and certain types of auditory hallucinations. These symptoms suggest Schizophrenia in the absence of an affective syndrome. The other kind of symptoms indicates Schizoaffective Disorder in the context of an affective syndrome, for example, preoccupation with a delusion or hallucination with content having no apparent relation to depression or elation.

With the exception of the differences already noted, the clinical features consist of various admixtures of affective and schizophrenic-like symptoms. There is some evidence that the complication of suicide is particularly common.

Subtyping. Schizoaffective Disorder is divided into three major subgroups on the basis of the nature of the affective symptomatology: manic, depressed, mixed. Each of these is further divided according to course: episodic, chronic, and in remission. These features are combined in the fifth digit as described following the diagnostic criteria (see p. 506).

Differential diagnosis. Since the diagnostic criteria for Schizoaffective Disorder combine criteria from both Affective Disorder and Schizophrenia, much of the discussion of differential diagnosis in the text for these disorders applies equally to Schizoaffective Disorder.

In Schizophrenia and Schizophreniform Disorder, dysphoric affect is common in all phases of the illness. Manic symptoms are less commonly present. These should be distinguished from the full affective syndromes. If the full affective syndrome is present, the differentiation from Schizophrenia and Schizophreniform Disorder hinges on the temporal relationship of the development of the symptoms.

In Affective Disorders psychotic symptoms are frequently present. Unless at least one of the psychotic symptoms is of the type specified in the diagnostic criteria, the diagnosis of Schizoaffective Disorder is not made.

Diagnostic Criteria for Schizoaffective Disorder

A. Has a depressive or manic syndrome (or mixture or rapid alternation) of at least 1 week's duration: Criteria A and B of Depressive Episode or Manic Episode).

B. Has at least one of the following nine symptoms (because a single symptom is given such diagnostic significance, its presence should be clearly established).

Symptoms From Criterion A of Schizophrenia

The following symptoms from Criterion A of
Schizophrenia are indicative of Schizoaffective Disorder in the context of an affective syndrome:

1. Delusions of control: Experiences his thoughts, actions, or feelings as imposed on him by some external force.
2. Thought broadcasting: Experiences his thoughts, as they occur, as being broadcast from his head into the external world so that others can hear them.
3. Thought insertion: Experiences thoughts, which are not his own, being inserted into his mind (other than from God).
4. Thought withdrawal: Belief that thoughts have been removed from his head, resulting in a diminished number of thoughts remaining.
5. Auditory hallucinations in which either a voice keeps up a running commentary on the individual's behavior or thoughts as they occur, or two or more voices converse with each other.
6. Auditory hallucinations on several occasions with content having no apparent relation to depression or elation, and not limited to one or two words.

Other Symptoms

The following symptoms also indicate Schizoaffective Disorder in the context of an affective syndrome:

7. Preoccupation with a delusion or hallucination to the relative exclusion of other symptoms or concerns, with content having no apparent relation to depression or elation.
8. Delusions (or hallucinations) that were concurrent with the affective syndrome, persisting for at least 1 month after the complete resolution of the affective disturbance.
9. Repeated instances of incoherence or derailment, unless concurrent with manic syndrome.

C. Depressive or manic syndrome overlaps temporally to some degree with the symptoms in B. The depressive or manic syndrome must precede or develop at the same time as the symptoms in B.

D. Duration of illness at least 1 week from the time of the first noticeable change in the individual's usual condition.

E. Not due to any Organic Mental Disorder.

Subtyping

Subtyping is noted in the fifth digit and combines both phenomenology of the current illness and the course of the disorder. Phenomenology is noted as predominantly depressed, manic, or mixed. Mixed is used when both Manic and Depressive Episodes are intermixed or rapidly alternating every few days. The course of the illness is noted as episodic (single or recurrent episode), chronic (duration of more than 2 years), or in remission. In remission should be used when an individual met the full criteria in the past and is now free of all clinical signs of the illness (whether or not on medication). The differentiation of Schizoaffective Disorder in Remission from No Mental Disorder requires consideration of the period of time since the last episode, the number of episodes, and the need for continued evaluation or prophylactic treatment. No precise guidelines can be offered at the present time.

295.7x Schizoaffective Disorder

1 = Manic, episodic.
2 = Manic, chronic.
3 = Manic, in remission.
4 = Depressed, episodic.
5 = Depressed, chronic.
6 = Depressed, in remission.
7 = Mixed, episodic.
8 = Mixed, chronic.
9 = Mixed, in remission.

Psychoses Not Classified Elsewhere

This section is for disorders with psychotic features that are not classified as either an Organic Mental Disorder or a Schizophrenic, Paranoid, Schizoaffective, or Affective Disorder. It contains two specific categories: Schizotypal Disorder and Brief Reactive Psychosis, and a residual category for all psychotic disorders that do not meet the criteria for any specific disorder: Atypical Psychosis.

The term "psychotic," as used in this manual, denotes the existence of any of the following: delusions, hallucinations, incoherence, repeated derailment, marked poverty of content of thought, marked illogicality, and behavior that is grossly disorganized or catatonic.

295.40 Schizotypal Disorder

The essential features are identical to those of Schizophrenia except that the duration is less than 6
months but more than 1 week. It is classified outside of the category of Schizophrenic Disorders because accumulated evidence suggests that it may have different external correlates, such as a greater likelihood of emotional turmoil and confusion, a better prognosis, a tendency toward acute onset and resolution, a more likely recovery to premorbid level of functioning, and the absence of an increase in the prevalence of Schizophrenia among family members as compared with the general population. The 6-month criterion has been chosen because several studies have indicated that this particular delineation is the most powerful known single way of differentiating these two disorders to maximize the difference in their external correlates. (Admittedly, in the past, the term “Schizophreniform” has been used to include cases that in this manual would be classified as Schizoaffective. Therefore, some of the conclusions drawn from that body of research may not apply to Schizophreniform Disorder as defined herein.)

With the exception of the differences in external correlates noted above, the features of Schizophreniform Disorder are likely the same as those of Schizophrenia.

Differential diagnosis. Since the diagnostic criteria for Schizophrenia and Schizophreniform Disorder differ only in duration of illness, most of the discussion of differential diagnosis in the text for Schizophrenia (pp. 499-500) applies equally to Schizophreniform Disorder.

Brief Reactive Psychosis differs from Schizophreniform Disorder in that the duration of the disturbance is less than 1 week (although secondary effects may persist for a longer period). In addition, by definition Brief Reactive Psychosis always follows an environmental stressor, which frequently is not present before the onset of a Schizophreniform Disorder. In some instances, what appears to be a Brief Reactive Psychosis may persist beyond 1 week. If the symptom picture is consistent with that of Schizophreniform Disorder, the diagnosis should be changed.

Atypical Psychosis should be diagnosed if the symptom picture is consistent with that of Schizophreniform Disorder but the duration is less than 1 week and the disturbance does not follow a psychosocial stressor.

Diagnostic Criteria for Schizophreniform Disorder

A. Meets all of the criteria for Schizophrenia (see pp. 500-501) except for duration.

B. Duration of illness (including prodromal, active and residual phases) is more than 1 week but less than 6 months.

298.80 Brief Reactive Psychosis

The essential feature is a psychosis (see above) of at least a few hours’ duration but lasting no more than 1 week, with sudden onset immediately following a recognizable stressor that would be expected to evoke significant symptoms of distress in almost all individuals. The precipitating event represents a major stress, such as the loss of a loved one or the psychological trauma of combat. The psychosis itself has no unique characteristics, but can represent a wide variety of psychotic pictures, elements of which may bear some relationship to the precipitating event.

Associated features. Frequently perplexity and emotional turmoil are evident. The perplexity presents as a feeling of confusion that the individual may acknowledge or that can be judged from the manner in which he responds to questions or requests. The emotional turmoil is manifested by rapid shifts from one dysphoric affect to another without the persistence of any one affect.

Behavior may be bizarre, including peculiar postures, outlandish dress, screaming, or muteness. Speech may include inarticulate gibberish or repetition of nonsensical phrases. Affect may be inappropriate and often volatile, involving such extremes of mood as anger, tearfulness, or euphoria. Transient hallucinations or delusions may be seen. There may be silly or obviously confabulated answers to factual questions. There may be confusion with clouding of consciousness, disorientation, and impairment in recent memory. Insight is usually quite limited.

Age at onset. Adolescents or young adults appear to be especially vulnerable, but exact data concerning age at onset are not yet available.

Course. Usually the psychosis clears in a day or two with full return to premorbid level of functioning. By definition this diagnosis is not given if the disorder persists for more than 1 week.

Impairment. During the illness the individual is usually incapacitated and needs considerable attention and assistance.

Complications. Although eventually there is full return to the premorbid level of adjustment, transient secondary effects, such as loss of self-esteem and mild depression, may follow the remission of the disorder. In some rare cases, a Brief Reactive Psychosis may provide symptoms that the individual
will later simulate as part of a Factitious Illness With Psychological Symptoms.

Predisposing factors. The predisposing factors have not yet been clearly identified except for a general impression that "unstable" individuals are more likely to have a transient psychotic reaction to stressful situations. Individuals with Histrionic, Schizotypal, and Borderline Personality Disorders are thought to be particularly vulnerable to the development of this disorder. Situations involving catastrophic stress, as warfare, predispose to the development of this disorder.

Prevalence, sex ratio, and familial pattern. No information.

Differential diagnosis. By definition this diagnosis is not given if the disorder persists for more than 1 week (although secondary effects may persist beyond 1 week). The diagnosis may be made soon after the onset of the disturbance, however, without waiting for the expected recovery. If the disorder lasts more than 1 week, the diagnosis should be changed to either Schizophreniform Disorder, Paranoid Disorder, Affective Disorder, or Atypical Psychosis.

Organic Mental Disorders, especially toxic or drug-related disorders, may only be distinguished from this disorder on the basis of historical information, suggesting either a known necessary organic factor, such as Substance Abuse, or evidence of a stressful situation. In general, Organic Brain Syndromes are more likely to resolve gradually, whereas an abrupt recovery is characteristic of Brief Reactive Psychosis.

Schizophreniform Disorder, by definition, requires a duration of more than 1 week. Furthermore, it is more likely to have an obvious prodromal phase, rarely remits suddenly, and frequently leaves residual deficits and personality changes.

Manic Episodes may start following an upsetting environmental event. The diagnosis of Manic Disorder is given when the criteria for it are met, whether or not it is related to an environmental event; it takes priority over the diagnosis of Brief Reactive Psychosis.

Individuals with a Personality Disorder may decompensate under stress and develop a psychotic disturbance with histrionic features, an entity once called hysterical psychosis. The Brief Reactive Psychosis should be noted on Axis I and the Underlying Personality Disorder on Axis II.

In Factitious Illness With Psychological Symptoms, psychotic symptoms may also appear under stressful circumstances. However, in such cases, the evidence will suggest that the symptoms are under the voluntary control of the individual.

When Malingering presents as a psychosis, there will be evidence of conscious feigning of the illness for an understandable goal.

Diagnostic Criteria for Brief Reactive Psychosis

A. The symptoms in B appear immediately following a recognizable stressor that would be expected to evoke significant symptoms of distress in almost all individuals.

B. The clinical picture involves emotional turmoil and at least one of the following:

1. Incoherence, derailment, or markedly illogical thinking.
2. Delusions.
3. Hallucinations.
4. Behavior that is grossly disorganized or catatonic.

C. The duration of the disorder is less than 1 week, but more than a few hours. (Note: Transient secondary effects, such as loss of self-esteem and mild depression, may persist beyond the 1 week. The diagnosis may be made soon after the onset of the disorder without waiting for the expected recovery. If the disorder lasts more than 1 week, the diagnosis should be changed.)

D. The disorder may be superimposed on another disorder (e.g., Personality Disorder), but this diagnosis should not be made if the symptoms in B are preceded by a period of increasing psychopathology.

E. Does not meet the criteria for an Organic Mental Disorder, Manic Episode, or Factitious Illness With Psychological Symptoms.

298.90 Atypical Psychosis

This is a residual category for individuals who have psychotic symptoms (delusions, hallucinations, incoherence, repeated derailment, marked poverty of content of thought, markedly illogical thinking, and behavior that is grossly disorganized or catatonic) who do not meet the criteria for any specific mental disorder.

Common examples of the use of this category include:

1. Psychoses with unusual features, e.g., monosymptomatic delusion of bodily change without accompanying impairment in functioning.
2. "Postpartum psychoses" that do not meet the criteria for an Organic Mental Disorder, Schizophreniform Disorder, Paranoid Disorder, or Affective Disorder.
(3) Psychoses that would be classified elsewhere except the duration is less than 1 week, e.g., the symptomatology of a Schizophreniform Disorder but duration only 3 days.

(4) Psychoses about which there is inadequate information to make a more specific diagnosis. (This is preferable to Diagnosis Deferred and can be changed with more information.)

(5) Psychoses with confusing clinical features so that a more specific diagnosis cannot be made.

301.22 Schizotypal Personality Disorder

The essential features are various oddities of thinking, perception, communication, and behavior, but never severe enough to meet the criteria for Schizophrenia. No single feature is invariably present. The disturbance in thinking may be expressed as magical thinking, ideas of reference, or paranoid ideation. Perceptual disturbances may include recurrent illusions, depersonalization, or derealization (not associated with panic attacks). Often there are marked peculiarities in communication; concepts may be expressed unclearly or oddly; words are used deviantly, but never to the point of derailment (loosening of associations) or incoherence. Frequently, but not invariably, the behavioral manifestations include social isolation and constricted or inappropriate affect that interferes with rapport in face-to-face interaction.

Associated features. Frequently, there are varying admixtures of anxiety, depression, and other dysphoric moods. Often there are features of Borderline Personality Disorder, and in some cases both diagnoses may be warranted. Because of peculiarities in thinking, such individuals are prone to eccentric convictions, such as bigotry and various fringe religious beliefs.

Impairment. Often there is some interference with social or occupational functioning.

Complications. There may be brief periods of bizarre behavior or oddities of thinking that approach delusional proportions. Short-lived psychotic episodes may occur and should be noted as additional diagnoses, such as episodic Schizoaffective Disorder, Schizophreniform Disorder, Brief Reactive Psychosis, Atypical Psychosis, and Paranoid State. Adjustment Disorders frequently occur as superimposed conditions. If the psychosis is of sufficient duration and has other features that justify a diagnosis of Schizophrenia, this Personality Disorder diagnosis is not made.

Prevalence and sex ratio. No information.

Familial pattern. There is some evidence that Chronic Schizophrenia is more common among family members with the disorder than among the general population.

Differential diagnosis. Schizotypal Personality Disorder is distinguished from Introverted Personality Disorder and Avoidant Personality Disorder by the presence of the oddities of behavior, thinking, perception, and communication that are only present in Schizotypal Personality Disorder. Frequently individuals with Schizotypal Personality Disorder will also meet the criteria for Borderline Personality Disorder. In such instances, both diagnoses should be given.

Diagnostic Criteria for Schizotypal Personality Disorder

The following are characteristic of the individual's long-term functioning and are not limited to episodes of illness.

A. At least four of the following are required:
   (1) Magical thinking, e.g., superstitiousness, clairvoyance, telepathy, "sixth sense," "others can feel my feelings."
   (2) Ideas of reference, self-referential thinking.
   (3) Social isolation, e.g., no close friends or confidants, social contacts limited to essential everyday tasks.
   (4) Recurrent illusions, sensing the presence of a force or person not actually present. (e.g., "I felt as if my dead mother were in the room with me"), depersonalization or derealization not associated with panic attacks.
   (5) Odd communication (not derailment [loose associations] or incoherence), e.g., speech that is tangential, digressive, vague, over-elaborate, circumstantial, metaphorical.
   (6) Inadequate rapport in face-to-face interaction due to constricted or inappropriate affect, e.g., aloof, distant, cold.
   (7) Suspiciousness or paranoid ideation.
   (8) Undue social anxiety or hypersensitivity to real or imagined criticism.

B. Does not meet the criteria for Schizophrenia.
schizophrenia conference proceedings published

The proceedings of the Second Rochester International Conference on Schizophrenia have recently been published in: Wynne, L.C.; Cromwell, R.L.; and Matthysse, S., eds., with the collaboration of Toohey, M.L.; Spring, B.J.; and Sugarman, J. The Nature of Schizophrenia: New Approaches to Research and Treatment. New York: John Wiley & Sons, Inc., 1978. The conference was held in Rochester, N.Y., on May 2-6, 1976, and was supported, in part, by the Clinical Research Branch of the National Institute of Mental Health.

Among the major topics covered in the 725-page volume are: Genetic Transmission; Biochemical Approaches; Central Nervous System and Psychophysiologic Approaches; Information Processing and Schizophrenia; Attention, Psychopharmacology, and Schizophrenia; Visual Tracking and Schizophrenia; Attention and Communication; Attentional Processes in Vulnerability to Schizophrenia; High Risk and Premorbid Development; Family Relationships and Communication; Epidemiologic and Sociocultural Approaches; Onset and Course; Diagnostic and Conceptual Issues.

In addition to the volume’s editors, the principal contributors include the following distinguished scientists:
