The definition and symptoms of psychosis

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In spite of more than 100 years of empirical research into schizophrenia and the psychoses, there is still no universally agreed upon definition of psychosis. In the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (American Psychiatric Association [APA], 2013), psychotic disorders are conceptualised in terms of a spectrum of severity and are characterised by the presence of five diverse symptom dimensions, namely, delusions, hallucinations, disorganised thinking (or thought disorder), grossly disorganised or abnormal motor behaviour and so-called negative symptoms.

In clinical practice and in research, symptoms of psychosis are often collapsed into two categories of positive and negative. **Positive symptoms** include hallucinations (and more subtle perceptual disturbances), delusions, **thought disorder** and **motor disturbances**. They are referred to as 'positive' since they entail the addition of disturbance. In contrast, **negative symptoms** refer to deficits in psychological processes including **avolition** (the loss of drive or motivation), **affective flattening** (a dampening down in the expression of emotion) and **alogia** (a lack of unprompted speech, also referred to as 'poverty of speech'). Although positive and negative symptoms constitute the defining symptoms for a diagnosis of a psychotic disorder, researchers have increasingly recognised that other features associated with psychotic disorders, especially problems with cognition, may be the most disabling aspects of these conditions. These associated problems are therefore likely to become an important area of increased attention for treatment, including early intervention and prevention (Insel, 2010).

positive symptoms In schizophrenia: hallucinations, delusions, and disorganisation in thought and behaviour.

thought disorder State of highly disorganised thinking (also known as formal thought disorder or a loosening of associations) characteristic of individuals with schizophrenia.

motor disturbance Disturbance of bodily movement.

negative symptoms In schizophrenia, deficits in functioning such as affective flattening, alogia and avolition.

avolition Inability to initiate or persist with important activities; negative symptom of schizophrenia.

affective flattening Severe reduction or the complete absence of affective (emotional) responses to the environment; negative symptom of schizophrenia.

alogia Deficiency in the quantity of speech; negative symptom of schizophrenia.

HALLUCINATIONS

Hallucinations are arguably the most distressing of psychotic symptoms. The *DSM-5* defines a hallucination as 'a perception-like experience with the clarity and impact of a true perception but without the external stimulation of the relevant sensory organ' (APA, 2013, p. 822). Approximately 75 per cent of patients diagnosed with schizophrenia report hallucinations (Bentall, 2006). These are generally **auditory hallucinations**, with between 60–70 per cent of patients diagnosed with schizophrenia reporting auditory hallucinations consisting of a voice speaking to them (Sartorius et al., 1986). Such voices are typically critical and hostile, but comforting voices are also reported. Command hallucinations, which entail specific instructions to the patient (e.g., to harm him/herself) are also described by between 33 per cent and 74 per cent of voice hearers (Braham, Trower, & Birchwood, 2004).

Hallucinations can occur in sensory modalities other than the aural, including visual (e.g., seeing the face of a tormentor), olfactory (sensations of smell, such as the experience of a rotting odour), gustatory (sensations of taste, such as a metallic taste), tactile (sensations of touch, such as a hand on one's shoulder) and somatic (perception of physical experience located within the body) (Assad & Shapiro, 1986). Multimodal hallucinations (e.g., a voice accompanied by the image of a figure) are also reported by patients. Hallucinations can be associated with neurological conditions including temporal lobe lesions, complex partial seizures, migraine and brain injury. Intoxication with illicit substances, such as **hallucinogens**, is associated with alterations in visual perception of the colour, size and shape of objects and the perception of more abstract images (Assad & Shapiro, 1986).

Interestingly, hallucinations are also known to be experienced by a sizeable minority of people in the general population, most of whom do not seek or require assistance, suggesting that the mere presence of hallucinations does not mark the presence of a mental disorder (Ohayon, 2000). This finding is consistent with a meta-analysis of psychotic symptoms in the general community that found that in about 70–95 per cent of cases, psychotic experiences disappear over time (van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009). However, in a small proportion of cases, especially when there are environmental risk factors, more serious psychosis that warrants treatment can develop.

TABLE 4.1 *DSM-5* types of psychotic disorders

DISORDER	DESCRIPTION
Schizophrenia	Lasts at least six months, with at least one month of two or more of the following: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour and/or negative symptoms
Schizotypal (personality) disorder	A pattern of pervasive social and interpersonal deficits and cognitive or perceptual distortions and eccentricities of behaviour beginning before early adulthood
Schizophreniform disorder	Equivalent to schizophrenia except the disturbance is of lesser duration (one to six months)
Schizoaffective disorder	The co-occurrence of the symptoms of schizophrenia and a major mood episode, in addition to at least a two-week period of delusions or hallucinations without mood disturbance. Mood symptoms are present for the majority of the total duration of the disorder.
Delusional disorder	At least one month of delusions
Brief psychotic disorder	A psychotic disturbance lasting more than one day but less than a month with eventual return to premorbid level of functioning
Psychotic disorder due to another medical condition	Prominent hallucinations or delusions that are the direct physiological consequence of another medical condition
Substance/medication-induced psychotic disorder	Delusions and/or hallucinations that develop during or soon after substance intoxication or withdrawal or after exposure to medication
Other specified schizophrenia spectrum and other psychotic disorder	Symptoms of psychosis that cause clinically significant distress or impaired functioning but which do not meet full criteria for any other psychotic disorders. Specific reasons for why the criteria for another disorder are not met must be specified by the clinician (e.g., persistent auditory hallucinations in the absence of other psychotic features).
Unspecified schizophrenia spectrum and other psychotic disorder	Symptoms of psychosis that cause clinically significant distress or impaired functioning but which do not meet full criteria for any other psychotic disorders. The clinician is not required to specify the reasons that the criteria for this diagnosis are met.

Some changes were made to the diagnostic criteria for schizophrenia from the *DSM-IV-TR* (APA, 2000) to the *DSM-5*. For example, the *DSM-IV-TR* specified that only one symptom needed to be present if it took a specific form (e.g., auditory hallucinations that kept up a running commentary on the person's behaviour or thoughts or if there were two or more voices conversing with each other). The *DSM-IV-TR* also stipulated some subtypes of schizophrenia that have been dropped from the *DSM-5*.

If the criteria for schizophrenia are not fully met, then other diagnoses may be relevant. For example, if only delusions are present and there is not a marked impact upon functioning, the diagnosis of delusional disorder may be applicable. If the duration criterion of six months of total disturbance is not met, then the diagnosis of schizophreniform disorder may apply. Alternatively, if there is a clear temporal association between the use of, or withdrawal from, substances or medication and the onset of psychotic symptoms (and the medication or substance is capable of producing the psychotic symptoms), then the diagnosis of substance-induced psychotic disorder can be made, although in clinical practice it can be difficult to infer a causal relationship in the case of individuals who have engaged in long-term substance use. In addition, clinicians need to be mindful of distinguishing substance-induced psychosis from intoxication: the latter may be associated with transient psychotic experiences, which would not warrant a formal diagnosis of a psychotic disorder.

Although a personality disorder rather than a psychotic disorder, schizotypal personality disorder is included in the *DSM-5* chapter on 'Schizophrenia Spectrum and Other Psychotic Disorders' because it is thought to occur on a continuum of severity of psychotic experiences. It describes a longstanding pattern of interpersonal, cognitive and perceptual disturbances that do not meet full criteria for a psychotic disorder.

The *DSM-5* also includes two other disorders where full criteria for a specific disorder are not met, namely, 'other specified' and 'unspecified' schizophrenia spectrum and other psychotic disorder. One controversial example was the inclusion of the attenuated psychosis syndrome as an example of 'other specified schizophrenia spectrum and other psychotic disorders'. Attenuated psychosis syndrome includes psychotic symptoms that are