- **Catatonic type:** prominent psychomotor abnormalities that may include extreme inactivity or excessive motor activity. **Cataplexy** (waxy flexibility) is rare in children and adolescents.
- **Undifferentiated type:** case in which a patient meets the diagnostic criteria for schizophrenia but not paranoid, disorganized, or catatonic type.
- **Residual type:** clinical situation in which full diagnostic criteria have been met previously but no current, prominent, positive symptoms.

To meet criteria for diagnosing schizophrenia, clinical symptoms should be present for at least 6 months. If symptoms are present for less than 1 month, the condition is called a **brief psychotic disorder.** If symptoms are present for more than 1 month but less than 6 months, a diagnosis of **schizophreniform disorder** is made. Psychotic symptoms that do not meet full diagnostic criteria for schizophrenia but are clinically significant are diagnosed as **psychotic disorder not otherwise specified.**

There are several disorders that have to be distinguished from schizophrenia. These include the following:

Schizoaffective disorder is diagnosed when a person has clear symptoms of schizophrenia for at least 2 weeks without active symptoms of depression or mania. These affective syndromes occur at other times, even when psychotic symptoms are present.

Major depression with psychotic features and **bipolar disorder with psychotic features** are diagnoses made when psychotic symptoms occur during the course of depression or mania only. Psychotic disorder due to a general medical condition describes psychotic symptoms that are judged to be the direct result of a general medical condition.

Substance-induced psychotic disorders have psychotic symptoms related to drug or alcohol ingestion.

Shared psychotic disorder, folie à deux, occurs when delusional symptoms from one person influence delusions, with similar content, in another person.

Other disorders in the differential diagnoses are autism, childhood disintegrative disorder (Heller syndrome), Asperger syndrome, drug-induced psychosis, and organic brain disorders.

No diagnostic tests or imaging studies are specific for schizophrenia. It is a clinical diagnosis of exclusion. Obtaining a family history with attention to mental illness is critical. The workup of schizophrenia includes physical and neurologic examinations, MRI, electroencephalography (to rule out epilepsy, especially temporal lobe epilepsy), drug screening, and metabolic screening for endocrinopathies. Evaluation to rule out Wilson disease and delirium is also indicated. Psychotic symptoms in younger children must be differentiated from manifestations of normal vivid fantasy life or abuse-related symptoms. Youth with posttraumatic stress disorder often have vivid recollections and nightmares related to abuse but sometimes are less specific and can include nightmares with other negative topics. Psychological testing can be helpful in identifying psychotic thought processes.

Treatment is based on a multimodal approach, including use of antipsychotic medications. First-line drugs are atypical antipsychotics (e.g., risperidone, olanzapine, quetiapine, aripiprazole, ziprasidone, and paliperidone). Second-line medications are typical antipsychotics (e.g., haloperidol, thiothixene, chlorpromazine, trifluoperazine, loxapine, and molindone). It is likely that the newer antipsychotics approved for adults will also work in youth. However, these are not yet approved in youth by the U.S. Food and Drug Administration. Antipsychotics can be augmented with lithium or another mood stabilizer. Clozapine or electroconvulsive therapy is generally reserved for resistant cases.

Psychosocial treatments, including skills training, supportive psychotherapy, behavior modification, and cognitive-behavioral therapy, are all appropriate and should be considered as needed for individual patients. Attention should be paid to psychoeducation for parents and the child about the disease and its treatments. School interventions are needed to ensure that any special learning needs are addressed.

The course of illness for schizophrenia varies in exacerbations and remissions of psychotic symptoms. The poorest prognosis is seen if the onset is at an age younger than 13 years, with poor premorbid function, when marked negative symptoms are present, and when a family history of schizophrenia exists.

Suggested Reading

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