01 - Chapter 3 Psychotic Disorders

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22 PSYCHOTIC DISORDERS Psychosis WARDS TIP Psychosis is exemplified by delusions, hallucinations, or severe disorganization of thought/behavior. DELUSIONS Delusions can also be

categorized by theme: PERCEPTUAL DISTURBANCES WARDS TIP Auditory hallucinations that directly tell the patient to perform certain acts are called command hallucinations. Psychosis is a general term used to describe a distorted perception of reality. Poor reality testing may be accompanied by delusions, perceptual disturbances (illusions or hallucinations), and/or disorganized thinking/behavior. Psychosis can be a symptom of schizophrenia, mania, depression, delirium, and major neurocognitive disorder (i.e., dementia), and it can be substance or medication-induced. Delusions are fixed, false beliefs that persist despite evidence to the contrary and that do not make sense within the context of an individual's cultural background. They can be categorized as either bizarre or nonbizarre. A nonbizarre delusion is a false belief that is plausible but is not true. Example: "The neighbors are spying on me by reading my e-mail." A bizarre delusion is a false belief that is impossible. Example: "Aliens are spying on me through a Wi-Fi connection in my brain." ■ Delusions of persecution/paranoid delusions: Irrational belief that one is being persecuted. Example: "The Central Intelligence Agency (CIA) is monitoring me and tapped my cell phone." ■ Delusions of reference: Belief that cues in the external environment are uniquely related to the individual. Example: "The TV characters are speaking directly to me." ■ Delusions of control: Includes thought broadcasting (belief that one's thoughts can be heard by others) and thought insertion (belief that outside thoughts are being placed in one's head). ■ Delusions of grandeur: Belief that one has special powers beyond those of a normal person. Example: "I am the all-powerful son of God and I shall bring down my wrath on you if I don't get my way." ■ Delusions of guilt: Belief that one is guilty or responsible for something. Example: "I am responsible for all the world's wars." ■ Somatic delusions: Belief that one has a certain illness or health condition. Example: A patient believing she is pregnant despite negative pregnancy tests and ultrasounds. ■ Illusion: Misinterpretation of an existing sensory stimulus (such as mistaking a shadow for an evil spirit). ■ Hallucination: Sensory perception without an actual external stimulus. ●Auditory: The most common modality experienced by patients with schizophrenia. ●Visual: Occurs in schizophrenia and other psychotic disorders, but less common. May accompany drug intoxication, drug and alcohol withdrawal, or delirium. ●Olfactory: Usually an aura associated with epilepsy. ●Tactile: Usually secondary to drug intoxication (e.g., cocaine or psychostimulants) or alcohol withdrawal.

DIFFERENTIAL DIAGNOSIS OF PSYCHOSIS ■ Psychotic disorder due to another medical condition. ■ Substance/Medication-induced psychotic disorder. ■ Delirium/Major neurocognitive disorder (dementia). ■ Bipolar disorder, manic/mixed episode. ■ Major depressive disorder with psychotic features. ■ Brief psychotic disorder. ■ Schizophrenia. ■ Schizophreniform disorder. ■ Schizoaffective disorder. ■ Delusional disorder. PSYCHOTIC DISORDER DUE TO ANOTHER MEDICAL CONDITION Other Medical causes of psychosis include:

1. Central nervous system (CNS) disease (cerebrovascular disease, multiple sclerosis, neoplasm, Alzheimer disease, Parkinson disease, Huntington disease, tertiary syphilis, epilepsy [often temporal lobe], encephalitis, prion disease, neurosarcoidosis, AIDS).
2. Endocrinopathies (Addison/Cushing disease, hyper/hypothyroidism, hyper/ hypocalcemia, hypopituitarism).
3. Nutritional/Vitamin deficiency states (B12, folate, niacin).
4. Other (connective tissue disease [systemic lupus erythematosus, temporal arteritis], porphyria). DSM-5 criteria for psychotic disorder due to another medical condition include: ■ Prominent hallucinations or delusions. ■ Symptoms do not occur only during an

episode of delirium. ■ Evidence from history, physical, or lab data to support another medical cause (i.e., not a primary psychiatric disorder). SUBSTANCE/MEDICATION-INDUCED PSYCHOTIC DISORDER Prescription medications that may cause psychosis in some patients include anesthetics, antimicrobials, corticosteroids, antiparkinsonian agents, anticonvulsants, antihistamines, anticholinergics, antihypertensives, nonsteroidal anti-inflammatory drugs (NSAIDs), digitalis, methylphenidate, and chemotherapeutic agents. Substances such as alcohol, cocaine, hallucinogens (LSD, ecstasy), cannabis, benzodiazepines, barbiturates, inhalants, and phencyclidine (PCP) can cause psychosis, either during intoxication or withdrawal. DSM-5 Criteria ■ Hallucinations and/or delusions. ■ Symptoms do not occur only during episode of delirium. ■ Evidence from history, physical, or lab data to support a medication or substance-induced cause. ■ Disturbance is not better accounted for by a psychotic disorder that is not substance/medication-induced. PSYCHOTIC DISORDERS WARDS TIP It's important to be able to distinguish between a delusion, illusion, and hallucination. A delusion is a fixed, false belief, an illusion is a misinterpretation of an external stimulus, and a hallucination is perception in the absence of an external stimulus. WARDS QUESTION Q: What is the most likely etiology in an elderly, medically ill patient presenting with the new onset of psychotic symptoms? A: Delirium. WARDS TIP To make the diagnosis of schizophrenia, a patient must have symptoms of the disease for at least 6 months.

24 PSYCHOTIC DISORDERS Schizophrenia KEY FACT Think of positive symptoms as things that are ADDED onto normal behavior. Think of negative symptoms as things that are SUBTRACTED or missing from normal behavior. WARDS TIP Stereotyped movement, bizarre posturing, and muscle rigidity are examples of catatonia, a syndrome which can be seen in schizophrenia, depression, bipolar disorder, and other psychiatric conditions. THREE PHASES WARDS TIP The 5 A's of schizophrenia (negative symptoms):

1. Anhedonia
2. Affect (flat)
3. Alogia (poverty of speech)
4. Avolition (apathy)
5. Attention (poor) DIAGNOSIS OF SCHIZOPHRENIA DSM-5 Criteria A 24-year-old male graduate student without prior medical or psychiatric history is reported by his mother to have been very anxious over the past 9 months, with increasing concern that people are watching him. He now claims to "hear voices" telling him what must be done to "fix the country." Important workup? Comprehensive metabolic panel, urine drug screen, thyroid-stimulating hormone (TSH), HIV testing. Consider brain imaging. Likely diagnosis? If workup is unremarkable, schizophrenia. Next step? Antipsychotics. Schizophrenia is a psychiatric disorder characterized by a constellation of abnormalities in thinking, emotion, and behavior. There is no single symptom that is pathognomonic, and there is a heterogeneous clinical presentation. Schizophrenia is typically chronic, with significant psychosocial and medical consequences to the patient. POSITIVE, NEGATIVE, AND COGNITIVE SYMPTOMS In general, the symptoms of schizophrenia are broken up into three categories: ■ Positive symptoms: Hallucinations, delusions, bizarre behavior, disorganized speech. These tend to respond more robustly to antipsychotic medications. ■ Negative symptoms: Flat or blunted affect, anhedonia, apathy, alogia, and lack of

interest in socialization. These symptoms are comparatively more often treatment resistant and contribute significantly to the social isolation and impaired function of schizophrenic patients. ■ Cognitive symptoms: Impairments in attention, executive function, and working memory. These symptoms may lead to poor work and school performance. Symptoms of schizophrenia often present in the following three phases:

6. Prodromal: Decline in functioning that precedes the first psychotic episode. The patient may become socially withdrawn and irritable. They may have physical complaints, declining school/work performance, and/or newfound interest in religion or the occult.
7. Psychotic: Perceptual disturbances, delusions, and disordered thought process/content.
8. Residual: Occurs following an episode of active psychosis. It is marked by mild hallucinations or delusions, social withdrawal, and negative symptoms. ■ Two or more of the following must be present for at least 1 month:
9. Delusions.
10. Hallucinations.
11. Disorganized speech.
12. Grossly disorganized or catatonic behavior.
13. Negative symptoms.

Note: At least one must be 1, 2, or 3. ■ Must cause significant social, occupational, or functional (self-care) deterioration. ■ Duration of illness for at least 6 months (including prodromal or residual periods in which the above full criteria may not be met). ■ Symptoms not due to effects of a substance or another medical condition. Mr. T is a 21-year-old man who is brought to the ER by his mother after he began talking about “aliens” who were trying to steal his soul. He reports that aliens leave messages for him by arranging sticks outside his home and sometimes send thoughts into his mind. On exam, he is guarded and often stops talking while in the middle of expressing a thought. Mr. T appears anxious and frequently scans the room for aliens, which he thinks may have followed him to the hospital. He denies any plan to harm himself, but admits that the aliens sometimes want him to throw himself in front of a car, “as this will change the systems that belong under us.” The patient’s mother reports that he began expressing these ideas a few months ago, but they have become more severe in the last few weeks. She reports that during the past year, he has become isolated from his peers, frequently talks to himself, and has stopped going to community college. He has also spent most of his time reading science fiction books and creating devices that will prevent aliens from hurting him. She reports that she is concerned because the patient’s father, who left while the patient was a child, exhibited similar symptoms many years ago and has spent most of his life in psychiatric hospitals. What is the patient’s most likely diagnosis? What differential diagnoses should be considered? Mr. T’s most likely diagnosis is schizophrenia. He exhibits delusional ideas that are bizarre and paranoid in nature. He also reports the presence of frequent auditory hallucinations and disturbances in thought process that include thought blocking. Although the patient’s mother reports that his psychotic symptoms began “a few months ago,” the patient has exhibited social and occupational dysfunction during the last year. Mr. T quit school, became isolated, and has been responding to internal stimuli since that time. In addition, his father appears to also suffer from a psychotic disorder. In this case, it appears that the disorder has been present for more than 6 months. However, if this is unclear, the diagnosis of schizophreniform disorder should be made instead. The differential diagnosis should also include schizoaffective disorder, medication/substance-induced psychotic disorder, psychotic disorder due to another medical condition, and mood disorder with psychotic features. What would be appropriate steps in

the acute management of this patient? Treatment should include inpatient hospitalization in order to provide a safe environment, with monitoring of suicidal ideation secondary to his psychosis. Routine laboratory tests, including a urine or serum drug screen, should be undertaken. The patient should begin treatment with antipsychotic medication while closely being monitored for potential side effects. PSYCHIATRIC EXAM OF PATIENTS WITH SCHIZOPHRENIA The typical findings in patients with schizophrenia include: ■ Disheveled appearance. ■ Flat affect. PSYCHOTIC DISORDERS WARDS TIP • Echolalia—Repeats words or phrases • EchoPRAxia—Mimics behavior (PRActices behavior) KEY FACT Brief psychotic disorder lasts for <1 month. Schizophreniform - disorder can last between 1 and 6 months. Schizophrenia lasts for

> 6 months.

26 ■ Disorganized thought process. PSYCHOTIC DISORDERS ■ Intact procedural memory and orientation. ■ Auditory hallucinations. ■ Paranoid delusions. ■ Ideas of reference. ■ Lack of insight into their disease. EPIDEMIOLOGY ●Women present in late 20s. compared to women. ■ There is a strong genetic predisposition: KEY FACT Schizophrenia is more prevalent in lower socioeconomic groups likely due to “downward drift” (many patients face barriers to higher education, regular employment, and other resources, so they tend to drift downward socioeconomically). DOWNWARD DRIFT Keep in mind that schizophrenia can have a very heterogeneous presentation— patients may have schizophrenia without a disheveled appearance or clear negative symptoms. ■ Schizophrenia affects approximately 0.3–0.7% of people over their lifetime. ■ Men and women are equally affected but have different presentations and outcomes: ●Men tend to present in early to mid-20s. ●Men tend to have more negative symptoms and poorer outcome ■ Schizophrenia rarely presents before age 15 or after age 55. ●Fifty percent concordance rate among monozygotic twins. ●Forty percent risk of inheritance if both parents have schizophrenia. ●Twelve percent risk if one first-degree relative is affected. ■ Substance use is comorbid in many patients with schizophrenia. The most commonly abused substance is nicotine (>50%), followed by alcohol, cannabis, and cocaine. ■ Post-psychotic depression is the phenomenon of schizophrenic patients developing a major depressive episode after resolution of their psychotic symptoms. Lower socioeconomic groups have higher rates of schizophrenia. This may be due to the downward drift hypothesis, which postulates that people suffering from schizophrenia are unable to function well in society and hence end up in lower socioeconomic groups. Many homeless people in urban areas suffer from schizophrenia. PATHOPHYSIOLOGY OF SCHIZOPHRENIA: THE DOPAMINE HYPOTHESIS Though the exact cause of schizophrenia is not known, it appears to be partly related to increased dopamine activity in certain neuronal tracts. Evidence to support this hypothesis is that most antipsychotics successful in treating schizophrenia are dopamine receptor antagonists. In addition, cocaine and amphetamines increase dopamine activity and can cause schizophrenia-like symptoms. Theorized Dopamine Pathways Affected in Schizophrenia ■ Prefrontal cortical: Inadequate dopaminergic activity; responsible for negative symptoms. ■ Mesolimbic: Excessive dopaminergic activity; responsible for positive symptoms.

Other Important Dopamine Pathways Affected by Antipsychotics ■ Tuberoinfundibular: Blocked by antipsychotics, causing hyperprolactinemia, which may lead to gynecomastia, galactorrhea, sexual dysfunction, and menstrual irregularities. ■ Nigrostriatal: Blocked by antipsychotics, causing

Parkinsonism/ extrapyramidal side effects such as tremor, rigidity, slurred speech, akathisia, dystonia, and other abnormal movements. OTHER NEUROTRANSMITTER ABNORMALITIES IMPLICATED IN SCHIZOPHRENIA ■ Elevated serotonin: Some of the second-generation (atypical) antipsychotics (e.g., risperidone and clozapine) antagonize serotonin and weakly antagonize dopamine. ■ Elevated norepinephrine: Long-term use of antipsychotics has been shown to decrease activity of noradrenergic neurons. ■ Low gamma-aminobutyric acid (GABA): There is lower expression of the enzyme necessary to create GABA in the hippocampus of patients with schizophrenia. ■ Low levels of glutamate receptors: Patients with schizophrenia have fewer NMDA receptors; this corresponds to the psychotic symptoms observed with NMDA antagonists like ketamine. PROGNOSTIC FACTORS Even with medication, 40–60% of patients remain significantly impaired after their diagnosis, while only 20–30% function fairly well in society. About 20% of patients with schizophrenia attempt suicide and many more experience suicidal ideation. Several factors are associated with a better or worse prognosis: Associated with Better Prognosis ■ Later onset. ■ Good social support. ■ Positive symptoms. ■ Mood symptoms. ■ Acute onset. ■ Female gender. ■ Few relapses. ■ Good premorbid functioning. Associated with Worse Prognosis ■ Early onset. ■ Poor social support. ■ Negative symptoms. ■ Family history. ■ Gradual onset. ■ Male gender. ■ Many relapses. PSYCHOTIC DISORDERS KEY FACT Akathisia is an unpleasant, subjective sense of restlessness and need to move, often manifested by the inability to sit still. Severe akathisia can be a risk factor for suicide. WARDS QUESTION Q: What are the most appropriate treatments for akathisia? A: Tapering down antipsychotic medication, beta-blockers such as propranolol, or benzodiazepines. KEY FACT The lifetime prevalence of schizophrenia is 0.3–0.7%. KEY FACT Schizophrenia has a large genetic component. If one identical twin has schizophrenia, the risk of the other identical twin having schizophrenia is 50%. A biological child of a schizophrenic person has a higher chance of developing schizophrenia, even if adopted into a family without - schizophrenia.

28 PSYCHOTIC DISORDERS KEY FACT ■ Comorbid substance use. TREATMENT Computed tomography (CT) and magnetic resonance imaging (MRI) scans of patients with schizophrenia may show enlargement of the ventricles, diffuse cortical atrophy, and reduced brain volume. KEY FACT Schizophrenia often involves neologisms. A neologism is a newly coined word or expression that has meaning only to the person who uses it. WARDS QUESTION Q: What is the typical age of onset for schizophrenia? A: For men, 15–25. For women, 15–30, with a second (smaller) peak incidence in the late 40s. WARDS TIP First-generation antipsychotic medications are referred to as typical or conventional antipsychotics (often called neuroleptics). Second-generation antipsychotic medications are referred to as atypical antipsychotics. ■ Poor premorbid functioning (social isolation, etc.). A multimodal approach is the most effective, and therapy must be tailored to the needs of the specific patient. Pharmacologic treatment consists primarily of antipsychotic medications. (For more detail, see Chapter 18, “Psychopharmacology.”) ■ First-generation (or typical) antipsychotic medications (e.g., chlorpromazine, fluphenazine, haloperidol, perphenazine): ●Primarily dopamine (mostly D2) antagonists. ●Treat positive symptoms with minimal impact on negative symptoms. ●Side effects include extrapyramidal symptoms, neuroleptic malignant syndrome, and tardive dyskinesia (see below). ■ Second-generation (or atypical) antipsychotic medications (e.g., aripiprazole, asenapine, clozapine, iloperidone, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone): ●These antagonize serotonin receptors (5-HT2) as well as dopamine (D4>D2) receptors. ●Research has not shown a significant difference between first- and second-generation antipsychotics in efficacy. The selection requires the weighing of benefits and

risks in individual clinical cases. ●Lower incidence of extrapyramidal side effects, but higher risk of metabolic syndrome. ●Medications should be taken for at least 4 weeks before efficacy is determined. ●Clozapine is reserved for patients who have failed multiple antipsychotic trials due to its risk of agranulocytosis. Behavioral therapy attempts to improve patients' ability to function in society. Patients are helped through a variety of methods to improve their social skills, become self-sufficient, and minimize disruptive behaviors. Family therapy and group therapy are also useful adjuncts. Important Side Effects and Sequelae of Antipsychotic Medications Side effects of antipsychotic medications include:

1. Extrapyramidal symptoms (especially with the use of high-potency first-generation antipsychotics): • Dystonia (spasms) of face, neck, and tongue. • Parkinsonism (resting tremor, rigidity, bradykinesia). • Akathisia (feeling of restlessness). • Treatment: Anticholinergics (benztropine, diphenhydramine), benzodiazepines/beta-blockers (specifically for akathisia).
2. Anticholinergic symptoms (especially low-potency first-generation antipsychotics and atypical antipsychotics): Dry mouth, constipation, blurred vision, hyperthermia. Treatment: As per symptom (eye drops, stool softeners, etc.).
3. Metabolic syndrome (second-generation antipsychotics): A constellation of conditions—elevated blood pressure, elevated blood sugar levels, excess

body fat around the waist, abnormal cholesterol levels—that occur together, increasing the risk for cardiovascular disease, stroke, and type 2 diabetes. Treatment: Consider switching to a first-generation antipsychotic or a more "weight-neutral" second-generation antipsychotic such as aripiprazole or ziprasidone. Consider metformin if the patient is not already on it. Monitor lipids and blood glucose measurements. Refer the patient to primary care for appropriate treatment of hyperlipidemia, diabetes, etc. Encourage appropriate diet, exercise, and smoking cessation. 4. Tardive dyskinesia (more likely with first-generation antipsychotics): Choreoathetoid movements, usually seen in the face, tongue, and head. Treatment: Discontinue or reduce the medication and consider substituting an atypical antipsychotic (if appropriate). VMAT-2 inhibitors such as valbenazine, benzodiazepines, Botox, and vitamin E may be used. The movements may persist despite withdrawal of the drug. Although less common, atypical antipsychotics can also cause tardive dyskinesia. 5. Neuroleptic malignant syndrome (NMS) (typically high-potency first-generation antipsychotics): ●Change in mental status, autonomic instability (high fever, labile blood pressure, tachycardia, tachypnea, diaphoresis), "lead pipe" rigidity, elevated creatine kinase (CK) levels, leukocytosis, and metabolic acidosis. Reflexes are decreased. ●NMS is a medical emergency that requires prompt withdrawal of all antipsychotic medications and immediate medical assessment and treatment. ●May be observed in any patient being treated with any antipsychotic (including second generation) medications at any time, but is more frequently associated with the initiation of treatment and at higher IV/IM dosing of high-potency neuroleptics. ●Patients with a history of prior neuroleptic malignant syndrome are at increased risk of recurrent episodes when retrialed with antipsychotic agents. 6. Prolonged QTc interval and other electrocardiogram changes, hyperprolactinemia (gynecomastia, galactorrhea, amenorrhea, diminished libido, and impotence), hematologic effects (agranulocytosis may occur with clozapine, requiring frequent blood draws when this medication is used), ophthalmologic conditions (thioridazine may cause irreversible retinal pigmentation at high doses; deposits in lens and cornea may occur with chlorpromazine), dermatologic conditions (such as rashes and photosensitivity).

Schizophreniform Disorder Diagnosis and DSM-5 Criteria The diagnosis of schizophreniform disorder is made using the same DSM-5 criteria as schizophrenia. The only difference is that in schizophreniform disorder the symptoms have lasted between 1 and 6 months, whereas in schizophrenia the symptoms must be present for >6 months. Prognosis One-third of patients recover completely; two-thirds progress to schizoaffective disorder or schizophrenia. Treatment Hospitalization (if necessary), 6-month course of antipsychotics, and supportive psychotherapy. PSYCHOTIC DISORDERS WARDS TIP Patients who are treated with first-generation (typical) antipsychotic medication need to be closely monitored for extrapyramidal symptoms, such as acute dystonia and tardive dyskinesia. WARDS TIP Patients with schizophrenia who are treated with second-generation (atypical) antipsychotic medications need a careful medical evaluation for metabolic syndrome. This includes checking weight, body mass index (BMI), fasting blood glucose or HbA1c, lipid assessment, and blood pressure. KEY FACT High-potency antipsychotics (such as haloperidol and fluphenazine) have a higher incidence of extrapyramidal side effects, while low-potency antipsychotics (such as chlorpromazine) have primarily anticholinergic and antiadrenergic side effects. WARDS QUESTION Q: What antipsychotic medications are available as long-acting injectables? A: First generation: haloperidol, fluphenazine. Second generation: risperidone, paliperidone, aripiprazole, olanzapine.

30 PSYCHOTIC DISORDERS Schizoaffective Disorder WARDS TIP Tardive dyskinesia occurs most often in older women after at least 6 months of medication. A small percentage of patients will experience spontaneous remission, so discontinuation of the agent should be considered if clinically appropriate. WARDS TIP The cumulative risk of developing tardive dyskinesia from antipsychotics (particularly first generation) is 5% per year. Treatment WARDS QUESTION Brief Psychotic Disorder Q: Which antipsychotic has been shown to reduce suicidality in patients with schizophrenia? A: Clozapine. WARDS TIP Clozapine is typically considered for treating schizophrenia when a patient fails both typical and other atypical antipsychotics. It is a very effective medication, but can cause agranulocytosis; therefore, patients' white blood cell and absolute neutrophil counts must be monitored regularly. Clozapine also has black box warnings for orthostatic hypotension, seizures, and cardiomyopathy. Other common side effects include sedation, excessive drooling, and severe constipation. Delusional Disorder ■ One or more delusions for at least 1 month. ■ Does not meet criteria for schizophrenia. Diagnosis and DSM-5 Criteria The diagnosis of schizoaffective disorder is made in patients who: ■ Meet criteria for either a major depressive or manic episode during which psychotic symptoms consistent with schizophrenia are also met. ■ Have delusions or hallucinations for 2 weeks in the absence of mood disorder symptoms (this criterion is necessary to differentiate schizoaffective disorder from a mood disorder with psychotic features). ■ Have mood symptoms for a majority of the psychotic illness. ■ Have symptoms not due to the effects of a substance (drug or medication) or another medical condition. Prognosis Worse with poor premorbid adjustment, slow onset, early onset, predominance of psychotic symptoms, long course, and family history of schizophrenia. ■ Hospitalization (if necessary) and supportive psychotherapy. ■ Medical therapy: Antipsychotics (second-generation medications may target both psychotic and mood symptoms); mood stabilizers, antidepressants, or electroconvulsive therapy (ECT) may be indicated for treatment of mood symptoms. Diagnosis and DSM-5 Criteria Patient with psychotic symptoms as in schizophrenia; however, the symptoms last from 1 day to 1 month, and there must be eventual full return to premorbid level of functioning. Symptoms must not be due to the effects of a substance (drug or medication) or another medical condition. This is a rare diagnosis, much less common than schizophrenia. It may be seen in reaction to extreme stress such as bereavement

and sexual assault. Prognosis High rates of relapse, but almost all completely recover. Treatment Brief hospitalization (usually required for workup, safety, and stabilization), supportive therapy, course of antipsychotics for psychosis, and/or benzodiazepines for agitation. Delusional disorder occurs more often in middle-aged or older patients (after age 40). Immigrants, the hearing impaired, and those with a family history of schizophrenia are at increased risk. Diagnosis and DSM-5 Criteria To be diagnosed with delusional disorder, the following criteria must be met:

TABLE 3-1. Schizophrenia versus Delusional Disorder Schizophrenia Delusional Disorder ■ Bizarre or nonbizarre delusions ■ Usually nonbizarre delusions ■ Daily functioning significantly impaired ■ Daily functioning not significantly impaired ■ Must have two or more of the following: ■ Does not meet the criteria for ■ Delusions ■ Hallucinations ■ Disorganized speech ■ Disorganized behavior ■ Negative symptoms ■ Functioning in life not significantly impaired, and behavior not obviously bizarre. ■ While delusions may be present in both delusional disorder and schizophrenia, there are important differences (see Table 3-1). Types of Delusions Patients are further categorized based on the types of delusions they experience: ■ Erotomanic type: Delusion that another person is in love with the individual. ■ Grandiose type: Delusions of having great talent. ■ Somatic type: Physical delusions. ■ Persecutory type: Delusions of being persecuted. ■ Jealous type: Delusions of unfaithfulness. ■ Mixed type: More than one of the above. ■ Unspecified type: Not a specific type as described above. Prognosis Better than schizophrenia with treatment: ■ >50%: Full recovery. ■ >20%: Decrease in symptoms. ■ <20%: No change. Treatment Difficult to treat, especially given the lack of insight and impairment. Antipsychotic medications are recommended despite somewhat limited evidence. Supportive therapy is often helpful. Culture-Specific Psychoses The following are examples of psychotic disorders seen within certain cultures: Psychotic Manifestation Culture Koro Intense anxiety that the penis will recede into the body, possibly leading to death. Southeast Asia (e.g., Singapore) Amok Sudden unprovoked outbursts of violence, often followed by suicide. Malaysia Brain fag Headache, fatigue, eye pain, cognitive difficulties, and other somatic disturbances in male students. Africa PSYCHOTIC DISORDERS WARDS TIP If a schizophrenia presentation has not been present for 6 months, think schizophreniform disorder. schizophrenia, as described in the left column KEY FACT Patients with borderline personality disorder may have transient, stress-related psychotic experiences. These are considered part of their underlying personality disorder and are not diagnosed as a brief psychotic disorder.

32 PSYCHOTIC DISORDERS Time Course ■ <1 month—Brief psychotic disorder. ■ 1–6 months—Schizophreniform disorder. ■ >6 months—Schizophrenia. KEY FACT SchizophreniFORM = the FORMation of a schizophrenic, but not quite there (i.e., <6 months). Comparing Time Courses and Prognoses of Psychotic Disorders Prognosis from Best to Worst Mood disorder with psychotic features > schizoaffective disorder > schizophreniform disorder > schizophrenia. QUICK AND EASY DISTINGUISHING FEATURES ■ Schizophrenia: Lifelong psychotic disorder. ■ Schizophreniform: Schizophrenia for >1 and <6 months. ■ Schizoaffective: Distinct mood episodes with psychosis persisting between mood episodes. ■ Schizotypal (personality disorder): Paranoid, odd or magical beliefs, eccentric, lack of friends, social anxiety. Criteria for overt psychosis are not met. [■ Schizoid (personality disorder): Solitary activities, lack of enjoyment from social interactions, no psychosis.

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