05 - 7.5 Brief Psychotic Disorder, Other Psychotic

7.5 Brief Psychotic Disorder, Other Psychotic Disorders, and Catatonia

and Catatonia BRIEF PSYCHOTIC DISORDER Brief psychotic disorder is defined as a psychotic condition that involves the sudden onset of psychotic symptoms, which lasts 1 day or more but less than 1 month. Remission is full, and the individual returns to the premorbid level of functioning. Brief psychotic disorder is an acute and transient psychotic syndrome. History Brief psychotic disorder has been poorly studied in psychiatry in the United States, partly because of the frequent changes in diagnostic criteria during the past 15 years. The diagnosis has been better appreciated and more completely studied in Scandinavia and other Western European countries than in the United States. Patients with disorders similar to brief psychotic disorder were previously classified as having reactive, hysterical, stress, and psychogenic psychoses. Reactive psychosis was often used as a synonym for good-prognosis schizophrenia, but a diagnosis of brief psychotic disorder is not meant to imply a relation with schizophrenia. In 1913, Karl Jaspers described several essential features for the diagnosis of reactive psychosis, including an identifiable and extremely traumatic stressor, a close temporal relation between the stressor and the development of the psychosis, and a generally benign course for the psychotic episode. Jaspers also stated that the content of the psychosis often reflected the nature of the traumatic experience and that the development of the psychosis seemed to serve a purpose for the patient, often as an escape from a traumatic condition. Epidemiology The exact incidence and prevalence of brief psychotic disorder is not known, but it is generally considered uncommon. The disorder occurs more often among younger patients (20s and 30s) than among older patients. Brief psychotic disorder is more common in women than in men. Such epidemiological patterns are sharply distinct from those of schizophrenia. Some clinicians indicate that the disorder may be seen most frequently in patients from low socioeconomic classes and in those who have experienced disasters or major cultural changes (e.g., immigrants). The age of onset in industrialized settings may be higher than in developing countries. Persons who have gone through major psychosocial stressors may be at

greater risk for subsequent brief psychotic disorder. Comorbidity The disorder is often seen in patients with personality disorders (most commonly, histrionic, narcissistic, paranoid, schizotypal, and borderline personality disorders).

Etiology The cause of brief psychotic disorder is unknown. Patients who have a personality disorder may have a biological or psychological vulnerability for the development of psychotic symptoms, particularly those with borderline, schizoid, schizotypal, or paranoid qualities. Some patients with brief psychotic disorder have a history of schizophrenia or mood disorders in their families, but this finding is nonconclusive. Psychodynamic formulations have emphasized the presence of inadequate coping mechanisms and the possibility of secondary gain for patients with psychotic symptoms. Additional psychodynamic theories suggest that the psychotic symptoms are a defense against a prohibited fantasy, the fulfillment of an unattained wish, or an escape from a stressful psychosocial situation. Diagnosis A diagnosis of brief psychotic disorder is appropriate when psychotic symptoms last at least 1 day but less than 1 month and are not associated with a mood disorder, a substance-related disorder, or a psychotic disorder caused by a general medical condition. There are three subtypes of brief psychotic disorder: (1) the presence of a stressor, (2) the absence of a stressor, and (3) a postpartum onset. As with other acutely ill psychiatric patients, the history necessary to make the diagnosis may not be obtainable solely from the patient. Although psychotic symptoms may be obvious, information about prodromal symptoms, previous episodes of a mood disorder, and a recent history of ingestion of a psychotomimetic substance may not be available from the clinical interview alone. In addition, clinicians may not be able to obtain accurate information about the presence or absence of precipitating stressors. Such information is usually best and most accurately obtained from a relative or a friend. Clinical Features The symptoms of brief psychotic disorder always include at least one major symptom of psychosis, such as hallucinations, delusions, and disorganized thoughts, usually with an abrupt onset, but do not always include the entire symptom pattern seen in schizophrenia. Some clinicians have observed that labile mood, confusion, and impaired attention may be more common at the onset of brief psychotic disorder than at the onset of eventually chronic psychotic disorders. Characteristic symptoms in brief psychotic disorder include emotional volatility, strange or bizarre behavior, screaming or muteness, and impaired memory of recent events. Some of the symptoms suggest a diagnosis of delirium and warrant a medical workup, especially to rule out adverse reactions to drugs. Scandinavian and other European literature describes several characteristic symptom patterns in brief psychotic disorder, although these may differ somewhat in Europe and America. The symptom patterns include acute paranoid reactions and reactive confusion, excitation, and depression. Some data suggest that, in the United States,

paranoia is often the predominant symptom in the disorder. In French psychiatry, bouffée délirante is similar to brief psychotic disorder. Precipitating Stressors. The clearest examples of precipitating stressors are major life events that would cause any person significant emotional upset. Such events include the loss of a close family member or a severe automobile accident. Some clinicians argue that the severity of the event must be considered in relation to the patient’s life. This view, although reasonable, may broaden the definition of precipitating stressor to include events unrelated to the psychotic episode. Others have argued that the stressor may be a series of modestly stressful events rather than a single markedly stressful event, but evaluating the amount of stress caused by a sequence of events calls for an almost impossibly high degree of clinical judgment. A 20-year-old man was admitted to the psychiatric ward of a hospital shortly after

starting military duty. During the first week after his arrival to the military base, he thought the other recruits looked at him in a strange way. He watched the people around him to see whether they were out “to get” him. He heard voices calling his name several times. He became increasingly suspicious and after another week had to be admitted for psychiatric evaluation. There he was guarded, scowling, skeptical, and depressed. He gave the impression of being very shy and inhibited. His psychotic symptoms disappeared rapidly when he was treated with an antipsychotic drug. However, he had difficulties in adjusting to hospital light. Transfer to a long-term medical hospital was considered, but after 3 months, a decision was made to discharge him to his home. He was subsequently judged unfit to return to military services. The patient was the eldest of five siblings. His father was an intemperate drinker who became angry and brutal when drunk. The family was poor, and there were constant fights between the parents. As a child, the patient was inhibited and fearful and often ran into the woods when troubled. He had academic difficulties. When the patient got older, he preferred to spend time alone and disliked being with people. He occasionally took part in local parties. Although he was never a heavy drinker, he often got into fights when he had a drink or two. The patient was reinterviewed by hospital personnel at 4 years, 7 years, and 23 years after his admission. He has had no recurrences of any psychotic symptoms and has been fully employed since 6 months after he left the hospital. He married, and at the last follow-up, he had two grown children. After leaving the hospital, the patient worked for 2 years in a factory. For the past 20 years, he has managed a small business, and it has run well. He has been very happy at work and in his family life. He has made an effort to overcome his tendency toward isolation and has several friends. The patient believes that his natural tendency is to be socially isolated and that his disorder was connected with the fact that in the military, he was forced to deal with other people. (Adapted from Laura J. Fochtmann, M.D., Ramin Mojtabai, M.D., Ph.D.,

M.P.H., and Evelyn J. Bromet, Ph.D.) Differential Diagnosis Clinicians must not assume that the correct diagnosis for a patient who is briefly psychotic is brief psychotic disorder, even when a clear precipitating psychosocial factor is identified. Such a factor may be merely coincidental. If psychotic symptoms are present longer than 1 month, the diagnoses of schizophreniform disorder, schizoaffective disorder, schizophrenia, mood disorders with psychotic features, delusional disorder, and psychotic disorder not otherwise specified must be entertained. If psychotic symptoms of sudden onset are present for less than 1 month in response to an obvious stressor, however, the diagnosis of brief psychotic disorder is strongly suggested. Other diagnoses to consider in the differential diagnosis include factitious disorder with predominantly psychological signs and symptoms, malingering, psychotic disorder caused by a general medical condition, and substance-induced psychotic disorder. In factitious disorder, symptoms are intentionally produced; in malingering, a specific goal is involved in appearing psychotic (e.g., to gain admission to the hospital); and when associated with a medical condition or drugs, the cause becomes apparent with proper medical or drug workups. If the patient admits to using illicit substances, the clinician can make the assessment of substance intoxication or substance withdrawal without the use of laboratory testing. Patients with epilepsy or delirium can also show psychotic symptoms that resemble those seen in brief psychotic disorder. Additional psychiatric disorders to be considered in the differential diagnosis include dissociative identity disorder and psychotic episodes associated with borderline and schizotypal personality disorders. Course and Prognosis By definition, the course of brief psychotic disorder is less than 1 month. Nonetheless, the development of such a significant psychiatric disorder may signify a patient’s mental vulnerability. Approximately half of patients who are first classified as having brief psychotic disorder later display chronic psychiatric

syndromes such as schizophrenia and mood disorders. Patients with brief psychotic disorder, however, generally have good prognoses, and European studies have indicated that 50 to 80 percent of all patients have no further major psychiatric problems. The length of the acute and residual symptoms is often just a few days. Occasionally, depressive symptoms follow the resolution of the psychotic symptoms. Suicide is a concern during both the psychotic phase and the postpsychotic depressive phase. Several indicators have been associated with a good prognosis. See Table 7.5-1 for a summary of good prognostic signs in brief psychotic disorder. Table 7.5-1 Good Prognostic Features for Brief Psychotic Disorder

Treatment Hospitalization. A patient who is acutely psychotic may need brief hospitalization for both evaluation and protection. Evaluation requires close monitoring of symptoms and assessment of the patient's level of danger to self and others. In addition, the quiet, structured setting of a hospital may help patients regain their sense of reality. While clinicians wait for the setting or the drugs to have their effects, seclusion, physical restraints, or one-to-one monitoring of the patient may be necessary. Pharmacotherapy. The two major classes of drugs to be considered in the treatment of brief psychotic disorder are the antipsychotic drugs and the benzodiazepines. When an antipsychotic drug is chosen, a high-potency antipsychotic drug, such as haloperidol, or a serotonin dopamine agonist such as ziprasidone may be used. In patients who are at high risk for the development of extrapyramidal adverse effects (e.g., young men), a serotonin dopamine antagonist drug should be administered as prophylaxis against medication-induced movement disorder symptoms. Alternatively, benzodiazepines can be used in the short-term treatment of psychosis. Although benzodiazepines have limited or no usefulness in the long-term treatment of psychotic disorders, they can be effective for a short time and are associated with fewer adverse effects than the antipsychotic drugs. In rare cases, the benzodiazepines are associated with increased agitation and, more rarely still, with withdrawal seizures, which usually occur only with the sustained use of high dosages. The use of other drugs in the treatment of brief psychotic disorder, although reported in case studies, has not been supported in any large-scale studies. Anxiolytic medications, however, are often useful during the first 2 to 3 weeks after the resolution of the psychotic episode. Clinicians should avoid long-term use of any medication in the treatment of the disorder. If maintenance medication is necessary, a clinician may have to reconsider the diagnosis. Psychotherapy. Although hospitalization and pharmacotherapy are likely to control short-term situations, the difficult part of treatment is the psychological integration of the experience (and possibly the precipitating trauma, if one was present) into the lives of the patients and their families. Psychotherapy is of use in providing an opportunity to discuss the stressors and the psychotic episode. Exploration and development of coping strategies are the major topics in psychotherapy. Associated

issues include helping patients deal with the loss of self-esteem and to regain selfconfidence. An individualized treatment strategy based on increasing problem-solving skills while strengthening the ego structure through psychotherapy appears to be the most efficacious. Family involvement in the treatment process may be crucial to a successful outcome. PSYCHOTIC DISORDER NOT OTHERWISE SPECIFIED Under the umbrella of psychosis not otherwise specified is a variety of clinical presentations that do not fit within current diagnostic rubrics. It includes psychotic symptomatology (i.e., delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior) about which there is inadequate information to make a specific diagnosis or about which there is contradictory information. It also includes disorders with psychotic symptoms

that do not meet the criteria for any specific psychotic disorder, such as patients who present to hospital with persistent auditory hallucinations that are not accompanied by mood disturbances and that are not pathognomonic for schizophrenia. Autoscopic Psychosis Although not included in DSM-5, autoscopic psychosis is of clinical interest. The characteristic symptom of autoscopic psychosis is a visual hallucination of all or part of the person's own body. The hallucinatory perception, which is called a phantom, is usually colorless and transparent, and because the phantom imitates the person's movements, it is perceived as though appearing in a mirror. The phantom tends to appear suddenly and without warning. Epidemiology. Autoscopy is a rare phenomenon. Some persons have an autoscopic experience only once or a few times; others have the experience more often. Although the data are limited, sex, age, heredity, and intelligence do not seem to be related to the occurrence of the syndrome. Etiology. The cause of the autoscopic phenomenon is unknown. A biological hypothesis is that abnormal, episodic activity in areas of the temporoparietal lobes is involved with the sense of self, perhaps combined with abnormal activity in parts of the visual cortex. Psychological theories have associated the syndrome with personalities characterized by imagination; visual sensitivity; and, possibly, narcissistic personality disorder traits. Such persons may likely experience autoscopic phenomena during periods of stress. Course and Prognosis. The classic descriptions of the phenomenon indicate that, in most cases, the syndrome is neither progressive nor incapacitating. Affected persons usually maintain some emotional distance from the phenomenon, an observation that suggests a specific neuroanatomical lesion. Rarely do the symptoms reflect the onset of

schizophrenia or other psychotic disorders. Treatment. Patients usually respond to antianxiety medication. In severe cases, antipsychotic medications may be needed. Motility Psychosis Motility psychosis is not considered an "official" DSM-5 diagnosis but is of clinical significance. It is probably a variant of brief psychotic disorder. The two forms of motility psychosis are akinetic and hyperkinetic. The akinetic form of motility psychosis has a clinical presentation similar to that of catatonic stupor. In contrast to the catatonic type of schizophrenia, however, akinetic motility psychosis has a rapidly resolving and favorable course that does not lead to personality deterioration. In its hyperkinetic form, motility psychosis can resemble manic or catatonic excitement. As with the akinetic form, the hyperkinetic form usually has a rapidly resolving and favorable course. Patients may switch from the akinetic to hyperkinetic form rapidly and may represent a danger to others during the excited phase. Mood is extremely labile in these patients. Postpartum Psychosis Postpartum psychosis (sometimes called puerperal psychosis) is an example of psychotic disorder not otherwise specified that occurs in women who have recently delivered a baby; the syndrome is most often characterized by the mother's depression, delusions, and thoughts of harming either her infant or herself. For a more detailed discussion see Section 21.1. PSYCHOTIC DISORDERS DUE TO A GENERAL MEDICAL CONDITION AND SUBSTANCE- OR MEDICATION-INDUCED PSYCHOTIC DISORDER The evaluation of a patient with psychotic disorders requires consideration of the possibility that the psychotic symptoms result from a general medical condition such as a brain tumor or the ingestion of a substance such as phencyclidine (PCP) or medication such as cortisol. Epidemiology Relevant epidemiological data about psychotic disorder caused by a general medical condition and substance-induced psychotic disorder are lacking. The disorders are most often encountered in patients who abuse alcohol or other substances on a long-term basis. The delusional syndrome that may accompany complex partial seizures is more common in women than in men. Etiology

Physical conditions such as cerebral neoplasms, particularly of the occipital or temporal areas (Fig. 7.5-1), can cause hallucinations. Sensory deprivation, as in people who are blind or deaf, can also result in hallucinatory or delusional experiences. Lesions involving the temporal lobe and other cerebral regions, especially the right hemisphere and the parietal lobe, are associated with delusions. FIGURE 7.5-1 Temporal meningioma. (From Rowland LP, Pedley TA. Merritt's Neurology. 12th edition. Philadelphia: Lippincott Williams & Wilkins; 2010.) Psychoactive substances are common causes of psychotic syndromes. The most commonly involved substances are alcohol, indole hallucinogens, such as lysergic acid diethylamide (LSD), amphetamine, cocaine, mescaline, PCP, and ketamine. Many other substances, including steroids and thyroxine, can produce hallucinations. Diagnosis Psychotic Disorder Due to a General Medical Condition. The diagnosis of psychotic disorder due to a general medical condition is defined by specifying the predominant symptoms. When the diagnosis is used, the medical condition, along with the predominant symptoms pattern, should be included in the diagnosis (e.g., psychotic disorder due to a brain tumor, with delusions). The disorder does not occur exclusively

while a patient is delirious or demented, and the symptoms are not better accounted for by another mental disorder. Substance- or Medication-Induced Psychotic Disorder. The diagnostic category of substance-induced psychotic disorder is reserved for those with psychotic symptoms and impaired reality testing caused by substances or medications. People with substance-induced psychotic symptoms (e.g., hallucinations) but with intact reality testing should be classified as having a substance-related disorder (e.g., PCP intoxication with perceptual disturbances). The full diagnosis of substance-induced psychotic disorder should include the type of substance or medication involved, the stage of substance use when the disorder began (e.g., during intoxication or withdrawal), and the clinical phenomena (e.g., hallucinations or delusions). See Table 7.5-2 for the DSM-5 diagnostic criteria. Table 7.5-2 DSM-5 Diagnostic Criteria for Substance- or Medication-Induced Psychotic Disorder

Clinical Features Hallucinations. Hallucinations can occur in one or more sensory modalities. Tactile hallucinations (e.g., a sensation of bugs crawling on the skin) are characteristic

of cocaine use. Auditory hallucinations are usually associated with psychoactive substance abuse; auditory hallucinations can also occur in persons who are deaf. Olfactory hallucinations can result from temporal lobe epilepsy; visual hallucinations can occur in persons who are blind because of cataracts. Hallucinations are either recurrent or persistent and are experienced in a state of full wakefulness and alertness; a hallucinating patient shows no significant changes in cognitive functions. Visual hallucinations often take the form of scenes involving diminutive (lilliputian) human figures or small animals. Rare musical hallucinations typically feature religious songs. Patients with psychotic disorder caused by a general medical condition and substanceinduced psychotic disorder may act on their hallucinations. In alcohol-related hallucinations, threatening, critical, or insulting third-person voices speak about the patients and may tell them to harm either themselves or others. Such patients are dangerous and are at significant risk for suicide or homicide. Patients may or may not believe that the hallucinations are real. Delusions. Secondary and substance-induced delusions are usually present in a state of full wakefulness. Patients experience no change in the level of consciousness, although mild cognitive impairment may be observed. Patients may appear confused, disheveled, or eccentric, with tangential or even incoherent speech. Hyperactivity and apathy may be present, and an associated dysphoric mood is

thought to be common. The delusions can be systematized or fragmentary, with varying content, but persecutory delusions are the most common. Differential Diagnosis. Psychotic disorder due to a general medical condition and substance- or medication-induced psychotic disorder must be distinguished from delirium (in which patients have a clouded sensorium), from dementia (in which patients have major intellectual deficits), and from schizophrenia (in which patients have other symptoms of thought disorder and impaired functioning). Psychotic disorder due to a general medical condition and substance-induced psychotic disorder must also be differentiated from psychotic mood disorders (in which other affective symptoms are pronounced). Treatment Treatment involves identifying the general medical condition or the particular substance involved. At that point, treatment is directed toward the underlying condition and the patient's immediate behavioral control. Hospitalization may be necessary to evaluate patients completely and to ensure their safety. Antipsychotic agents (e.g., olanzapine [Zyprexa] or haloperidol) may be necessary for immediate and short-term control of psychotic or aggressive behavior, although benzodiazepines may also be useful for controlling agitation and anxiety. CATATONIC DISORDER

Catatonia is a new diagnostic category in DSM-5 introduced because it can occur over a broad spectrum of mental disorders, most often in severe psychotic and mood disorders. It can also be caused by an underlying medical condition or induced by a substance. Definition Catatonia is a clinical syndrome characterized by striking behavioral abnormalities that may include motoric immobility or excitement, profound negativism, or echolalia (mimicry of speech) or echopraxia (mimicry of movement). A diagnosis of catatonic disorder due to a general medical condition can be made if there is evidence that the condition is due to the physiological effects of a general medical condition. The diagnosis is not made if the catatonia is better explained by a primary mental disorder, such as schizophrenia or psychotic depression, or if catatonic symptoms occur exclusively within the course of delirium. Epidemiology Catatonia is an uncommon condition mostly seen in advanced primary mood or psychotic illnesses. Among inpatients with catatonia, 25 to 50 percent are related to mood disorders (e.g., major depressive episode, recurrent, with catatonic features), and approximately 10 percent are associated with schizophrenia. The prevalence of catatonia due to medical conditions of substances is unknown. Etiology Medical conditions that can cause catatonia include neurological disorders (e.g., nonconvulsive status epilepticus, and head trauma), infections (e.g., encephalitis), and metabolic disturbances (e.g., hepatic encephalopathy, hyponatremia, and hypercalcemia). Medications that can cause catatonia include corticosteroids, immunosuppressants, and antipsychotic (i.e., neuroleptic) agents. Catatonic symptoms may be seen in extreme forms of neuroleptic-induced parkinsonism or neuroleptic malignant syndrome, a rare, potentially life-threatening disorder associated with fever, autonomic instability, impaired consciousness, and rigidity. Diagnosis and Clinical Features DSM-5 criteria for the diagnosis of catatonic disorder due to a general medical condition (Table 7.5-3) include behavioral changes characteristic of catatonia, evidence of a physiological basis for the symptoms, and exclusion of primary mental disorders and delirium. The diagnosis of catatonia due to a mental disorder is used when the disorder occurs in a psychiatric rather than another medical condition (Table 7.5-4). In either case, the signs and symptoms of catatonia are similar; it is the etiology that differs. Behavioral changes may include motoric immobility or excessive activity, extreme

negativism or mutism, peculiarities of voluntary movement, and echolalia or echopraxia. Waxy flexibility, a form of artificial posturing often evident on physical examination, may be present (Fig. 7.5-2). Lethal catatonia is a rare advanced stage of the disorder that features fever and autonomic

instability and may be fatal. FIGURE 7.5-2 A chronic schizophrenic patient stands in a catatonic position. He maintained this uncomfortable position for hours. (Courtesy of Emil Kraepelin, M.D.) Table 7.5-3 DSM-5 Diagnostic Criteria for Catatonic Disorder Due to Another Medical Condition

Table 7.5-4 DSM-5 Diagnostic Criteria for Catatonia Associated with Another Mental Disorder For catatonia secondary to antipsychotic agents, the diagnoses of neuroleptic-induced parkinsonism and neuroleptic malignant syndrome may be appropriate. For catatonia due to non-neuroleptic substances, the diagnosis of medication-induced movement disorder not otherwise specified is available. Laboratory Examination There are no pathognomonic laboratory findings in catatonia. The laboratory

evaluation should be used to rule out an underlying medical condition. Appropriate medical tests may include complete blood counts, electrolytes, brain imaging, and electroencephalography (if seizures are suspected). In addition, serum creatinine phosphokinase, white blood cell count, and serum transaminases should be checked because the results of laboratory tests are elevated in patients with neuroleptic malignant syndrome. Differential Diagnosis Differential diagnoses include hypoactive delirium, end-stage dementia, and akinetic mutism, as well as catatonia due to a primary psychiatric disorder. It is important to identify cases of catatonia occurring in the setting of neuroleptic malignant syndrome because the latter diagnosis can be fatal. Features suggesting neuroleptic malignant syndrome include autonomic instability and delirium in addition to elevated serum creatinine phosphokinase, white blood cell count, and serum transaminases. Course and Treatment Catatonia impairs a person’s ability to care for himself or herself and therefore requires hospitalization. In an excited state, the catatonic patient may represent a danger to others; hence, close supervision is needed. Fluid and nutrient intake must be maintained, often with intravenous lines or feeding tubes. The catatonic individual must be assisted with hygiene. The primary treatment modality is identifying and correcting the underlying medical or pharmacological cause. Offending substances must be removed or minimized. Benzodiazepines can provide temporary improvement in symptoms, and their use may improve patients’ ability to communicate and to care for themselves. ECT is appropriate for catatonia due to a general medical condition, especially if the catatonia is life threatening (e.g., inability to eat) or has developed into lethal (malignant) catatonia. The mechanism behind the efficacy of ECT is unknown. REFERENCES Breen R. Psychotic disorders. In: Thornhill JT, ed. NMS Psychiatry. 6th edition. Baltimore: Lippincott Williams & Wilkins: 2011:17. Correll CU, Smith CW, Auther AM, McLaughlin D, Shah M, Foley C, Olsen R, Lencz T, Kane JM, Cornblatt BA. Predictors of remission, schizophrenia, and bipolar disorder in adolescents with brief psychotic disorder or psychotic disorder not otherwise specified considered at very high risk for schizophrenia. J Child Adolesc Pscyhopharmacol. 2008;18:475. Fochtmann LJ, Mojtabai R, Bromet EJ. Other psychotic disorders. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry, 9th edition. Philadelphia: Lippincott Williams & Wilkins: 2009: 1605. Hasija D, Jadapalle SLK, Badr A. Status epilepticus and psychosis of epilepsy. Psych Ann. 2012:42:11. Hedges DW, Woon FL, Hoppes SP. Caffeine-induced psychosis. CNS Spectr. 2009:14:127. Jacobson SA. Psychotic disorder due to a general medical condition (secondary psychosis). In: Laboratory Medicine in Psychiatry and Behavioral Science. Arlington, VA: American Psychiatric Publishing; 2012:554.

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