Other Psychotic Disorders

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Other Psychotic Disorders

- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Shared Psychotic Disorder
- Axis II- associated psychoses
- Culture- bound syndromes

Brief Psychotic Disorder

:Diagnostic Criteria
:Presence of 1 or more of the following
Delusions
Hallucinations
Disorganized speech
Grossly disorganized or catatonic behavior

Duration: at least a day, but less than a month
Diagnosis is given after person has fully recovered in less than a month

No other medical cause, not secondary to substance

Brief Psychotic Disorder

!Per definition- always full recovery

Good prognosis- 50-80% never develop any psychiatric disease. Others- develop F20 or affective diseases

Specifiers for Brief Psychotic Disorder

With Marked Stressors= brief reactive psychosis

Without Marked Stressors

With Postpartum Onset: within 4 weeks postpartum

Epidemiology

Rare. Prevalence unknown. Most patients- young (20-30y), women, from developing countries

Personality disorders

Low SES

After natural disasters, severe stressors, emmigration

Clinical Presentation

Typically- extreme emotional lability, bizzarre behavior, either screaming or complete mutism, severe impairment of short- term memory (almost never recall the episode)

<u>Assess as any secondary psychosis or delirium- !always r/o organic cause</u>

Brief Psychotic Disorder
Good Prognostic Indicators

No prodrome, acute onset
Good premorbid level of functioning
Few schizoid personality traits
Severe stressor before onset
Affective symptoms during the episode
Severe confusion and perplexity during the episode
No affective blunting
Short duration of symptoms
No relatives with F20

<u>As a rule- the more dramatic, acute and "frightening" presentation- the better the !outcome</u>

DDX

- Any substance (intoxication, withdrawal, secondary psychosis)
- Any other general medical condition
- Schizophreniform
- Delusional
- Affective psychosis
- Factitious and malingering
- Short transient psychosis in personality disorder
- Dissociative state

Treatment

Hospitalization

Antipsychotics- usually good and fast response

Psychotherapy to deal with the potential trigger and with the episode of psychosis

Postpartum Psychosis (PPP)

births 1-2/1000

Risk factors- personal or family HX of bipolar, schizoaffective or isolated PPP

recurrence 75%

-first presentation of bipolar. 10-15% -85% first presentation of F20

Rare- single episode w/o recurrences (this is not the rule!)

”PPP- “the Rule of 50%

first childbirth -50-60%

no previous psychiatric HX that is- the first -50% presentation of illness

family HX of any affective disease -50%

At least 50% (up to 70%)- develop another episode of the underlining disease (usually mania) in the first year after childbirth

Clinical Presentation

Acute onset- 2days- 2 weeks after childbirth. Almost all cases within 1 month

Presenting symptom- severe sleep disturbance

Symptoms as in any brief psychotic disorder, although usually very extreme and delirium- like: Extreme agitation, very bizzarre and disorganized behavior, severe impairment of thought process, elated or irritable and modalities, labile mood, inappropriate affect, hallucinations in 25% (in all command hallucinations), delusions in 50% (usually bizzarre and mood-incongruent, centered on the newborn), suicidality (5%), extreme aggressiveness (4% infanticide), catatonia

!Medical emergency

Treatment of PPP

Always hospitalize! In many cases- compulsory hospitalization is imminent

Since this is usually the presentation of bipolar- treat as psychotic mania: mood stabilizers+ antipsychotics+ BZ

In severe cases (suicidality, aggressiveness, catatonia)- ECT

Sufficient sleep is important for recovery

If known bipolar or F20- institute maintenance treatment

Consider prophylaxis in subsequent pregnancies

SCHIZOPHRENIFORM DISORDER

A. 2 or more of the following sx are present for at least a month: delusions, hallucinations, catatonic disorganized speech, disorganized or behavior, negative sx

B. R/O schizoaffective disorder, mood disorders, and the effects of a substance or general medical condition

C. An episode of the disorder (including prodromal, active, & residual phases) lasts at least a month but less than 6 months

D. Provisional diagnosis prior to 6 months

Shizophreniform Disorder: Specifiers

Without Good Prognostic Features

With Good Prognostic Features – as evidenced by :2 or more of the following

acute onset of Sx (<4 weeks after prodrome)

confusion or perplexity at height of psychotic episode

good premorbid social and occupational functioning

absence of blunted or flat affect

Schizophreniform Disorder (cont.)

Age- young adults

Prevalence- 0.1-0.2%

More affective diseases than in the families of patients with schizophrenia

More affective psychoses than in the families of patients with bipolar

DDX: like F20 (including F20)

Treatment- like F20

Prognosis- 60-80% develop F20 eventually. Others- complete recovery. More chances of F20 if multiple attacks in 6 months needed for diagnosis (=repeated)

Treatment

months of neuroleptics. React faster and 3-6 better than F20

ECT in patients with affective or catatonic characteristics

Schizoaffective Disorder Diagnosis

- A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia
- B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms
- C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness
- D. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition

Lake CR, Hurwitz N (2007), Curr Opin Psychiatry 20(4):365-379

Diagnostic Criteria for Schizoaffective Disorder

Overlap of mood sx & psychotic sx

week period of psychotic sx without mood sx 2

Mood sx are prominent & enduring part of clinical picture (15-20% of the period of illness)

:Specifiers

Bipolar Type – disturbance includes manic or mixed episode

Depressive Type – disturbance includes major depressive episode

Schizoaffective Disorder (cont.)

Prevalence- 0.5-0.8%

Depressive type- more prevalent in the older patients

Bipolar type- more prevalent in the younger patients

The disease is more prevalent in women, in women- later onset, fewer negative signs, less blunting of affect, fewer antisocial characterystics than in men. Overall- better prognosis

Schizoaffective Disorder (cont.)

More F20 in the families of patients

Prognosis- better than F20, worse than affective diseases. The more "schizo" characterystics- the worse the prognosis

Treatment- mood stabilizers + antipsychotics. Carbamazepine- very affective in the depressive type

!Beware of antidepressants- high chance of switch
Prescribe only with mood stabilizers

Intractable manic symptoms- ECT

DELUSIONAL DISORDER

:Diagnostic Criteria

A. Presence of 1 or more nonbizarre delusions (involve plausible situations, e.g. being followed, poisoned, infected, loved at a distance, betrayed by a lover, or .having a disease) of at least 1 month's duration

B. Criteria A for Schizophrenia has never been met (no hallucinations and if there are- only in the context of the dellusion)

C. Aside from impact of delusion(s), functioning is not markedly impaired and behavior is not obviously odd

.or bizarre

D. No prominent affective sx, if there are- only of short .duration

C. Not secondary to substance or another medical .condition

Subtypes for Delusional Disorder

:Based on prominent delusional theme

Erotomanic: belief that another person, usually of higher status, is in love with you

knowledge, Grandiose: belief that you have inflated worth, power, identity, or a special relationship to a prominent person

Jealous: belief that lover is unfaithful

Persecutory: belief that you're being treated malevolently, e.g. cheated, conspired against, poisoned, spied on

Somatic: belief that you have a physical defect or some medical condition

Mixed: >1 of above themes; no 1 theme predominates

Unspecified: central theme doesn't fit other types

Delusional Disorder (cont.)

Prevalence 0.3%

Average age- 40y

.More prevalent in women

.In women- more erotomanic type. In men- more jealous type

.Most patients are married, working and generally functional

.More in immigrants, hearing impairment, low SES

More delusional disorder in the families. No genetic association to affective .diseases or F20. More cluster A personalities in the families

!Always r/o organic cause

Delusional Disorder (cont.)

Stable diagnosis: <25% develop F20, ,10% turn out to be affective. 50% recover, 20% improve, 30% no change

.Therefore- a separate disease

Prognosis is good in women, good overall functioning, acute onset, onset younger than 30y, short duration, stress causative factors, types- paranoid/ somatic/erotomanic

Delusional Disorder (cont.)

Treatment- extremely treatment- resistant. Most patients refuse treatment because they do not .feel or believe they are ill

.Resistant to antipsychotics. Best option- typicals

is The only psychotic illness in which psychotherapy the primary treatment option- teach the patient to cope and live with the symptoms without .trying to make the dellusion disappear

Shared Delusional Disorder (Folie a Deux)

A. A delusion develops in an individual in the context of a close relationship with another person(s), who has an already-established delusion.

B. The delusion is similar in content to that of the person who already has the established delusion.

C. The disturbance is not better accounted for by another Psychotic Disorder (e.g., Schizophrenia) or a Mood Disorder With Psychotic Features and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Shared Delusional Disorder (Folie a Deux)

Extremely rare. Only case reports, no controlled studies

Usually in two persons living in isolated environment and being in close relationship, where the primary psychosis patient usually has chronic psychiatric disease and is the dominant one, while the secondary patient has no previous psychiatric history and is a submissive one

Treatment always involves separation. Primary patient should be medically treated. Secondary patient usually recovers spontaneously after the Separation

Prognosis in the primary patient- depending on the disease. Prognosis in the secondary patient- similar to delusional disorder

Capgras' syndrome

A delusional condition in which a patient falsely believes that someone, usually a close relative

.or friend, has been replaced by an imposter

!It is not rare

Can be part of a psychiatric illness, organic diseases, drug .usage, and rarely as an independent phenomenon

Capgras syndrome, associated with other medical etiologies, usually resolves following resolution of the primary pathology

Axis II Disorders associated with Psychosis

Stress + Predisposition

Borderline and Schizotypal. In some cases- schizotypal patients subsequently progress to F20

Possible- paranoid, antisocial (rarely)

Treatment includes antipsychotic and psychotherapy

Culture- Bound Syndromes

Piblokto/Pibloktoq

Region/Culture: Arctic and Subarctic Eskimos

***Piblokto*, also known as "arctic hysteria," describes a dissociative episode in which patients experience prolonged, extreme excitement sometimes followed by seizures and coma. A prodrome of irritability can occur, and during the episode patients frequently exhibit dangerous, irrational behavior (ie, .property destruction, stripping naked)**

food Probably result from vitamin A toxicity; organ meat from Arctic sources such as polar bears, seals, and walruses contains extremely high levels of the vitamin

Other potential causes of this syndrome include forms of malnutrition (eg, vitamin D or calcium deficiency) and the conditions associated with *amok*, including delirium and severe psychotic, mood, or personality disorders

Clinical Lycanthropy

Region/Culture: Various

Lycanthropy is a rare condition in which sufferers experience the delusion of transforming into an animal. Affected people may also behave like the animal they believe they have turned into. Wolf and dog transformations are most commonly described, but transformations into other animals, including birds and insects, have also been reported. In that sense, the syndrome may be shaped by personal, cultural, and .regional influences

Effectively a specific form of a delusional misidentification syndrome, it is not surprising that lycanthropy typically occurs in the context of schizophrenia, psychotic mood .disorders, or substance-induced psychoses

Wendigo Psychosis

Region/Culture: Various

***Wendigo* psychosis describes an insatiable craving for human flesh even when other food is available. It was first described in Algonquin Indians who felt that tribe members engaging in cannibalism then turned into, or were occupied by, a feared, flesh-eating creature or spirit called the *wendigo*. If attempts at a cure by traditional native healers or Western doctors failed and the person went on to threaten others or act violently, execution of the sufferer often followed. While some have denied the validity of this disorder, there are a number of credible eyewitness accounts, by both aboriginal and nonaboriginal peoples. A psychotic origin of these behaviors cannot be excluded**

Amok (running amok)/*Berserker*

Region/Culture: Southeast Asia, Scandinavia
Loosely translated as "rampage" in Malay, *amok* is a dissociative condition characterized by a non-premeditated violent, disorderly, or homicidal rage directed against other objects or persons. The condition, which is often accompanied by amnesia and exhaustion, is typically incited by a perceived or actual insult and can occur as part of a brief psychotic episode or as an exacerbation of a chronic psychotic illness. A similar state, *berserker*, is used in Old Norse literature to describe a frenzied rage in Viking warriors. Conditions such as intermittent explosive disorder; catatonic excitement; agitation and aggression under the influence of substances; and aggression associated with psychotic, mood, or personality disorders share features with *amok*

Taijin Kyofusho

Region/Culture: Japan

of Patients with *taijin kyofusho* (literally "the disorder fear") experience extreme self-consciousness regarding their appearance. Patients suffer from intense, disabling fear that their bodies are .embarrassing or offensive to others

This culture-bound condition has overlapping features .with social phobia and body dysmorphic disorder

Koro

Region/Culture: Asia, Southeast Asia
***Koro* is intense anxiety related to the belief that one's own genitalia are shrinking or receding, resulting in possible death. Localized epidemics have been reported. *Koro*, rooted in Chinese metaphysics and cultural practices, is included in the *Chinese Classification of Mental Disorders*, Second Edition.The disorder has also been associated with the belief that perceived inappropriate sexual acts (eg, extramarital sex, sex with prostitutes, or masturbation) disrupt the yin/yang equilibrium, thought to be achieved during marital sex. *Koro* has also been thought to be transmitted through food. One could also hypothesize that excessive guilt and shame about fantasized or .executed sexual acts might play a role in the delusional belief**

Zar

Region/Culture: Northern Africa, Middle East
Attributed to spirit possession -- and not considered a pathology locally -- people experiencing *zar* undergo dissociative episodes, including fits of excessive laughing, yelling, crying, and hitting their head against a wall. Patients are often apathetic and report developing long-term relationships with their possessor. On the basis of its phenomenology, *zar* could be conceptualized as a recurrent brief psychotic episode, delusional disorder, dissociative condition, or potentially a substance-induced event. *Zar* is an important example of how certain culture-bound syndromes can be seen as normal, or as a sign of being "selected," where other cultures would consider such symptoms .pathologic

Ghost Sickness

Region/Culture: Native Americans, Hispanics
Ghost sickness is characterized by a preoccupation with death and the deceased and is frequently seen in Native Americans but has also been described in Hispanic cultures. Symptoms are broad and can include weakness, dizziness, loss of appetite, feelings of danger, dizziness, fear, anxiety, hallucinations, and a sense of suffocation. As evidenced by this symptom constellation, ghost sickness could also be conceptualized as expressed protracted or pathological grief or depression, which is predominantly somatically and may increase the acceptability of the disturbed mental state to afflicted people and those who know them.

Gururumba

Region/Culture: New Guinea
***Gururumba* describes an episode in which the afflicted person (usually a married man) begins burglarizing neighboring homes, taking objects that he considers valuable but which seldom are. He then runs away, often for days, returning without the objects and amnestic about the episode. Sufferers have been described as hyperactive, clumsy, and with slurred speech. This syndrome has features of a dissociative or conversion disorder but also could be a substance intoxication-related condition**

!Test Yourself

A 19 year old man is brought to the physician by his parents after he called them from college, terrified that the Mafia was after him. He states he has eaten nothing for the past 6 weeks other than canned beans because “they are into everything – I can’t be too careful.” He is convinced that the Mafia has put cameras in his dormitory room and that they are watching his every move. He occasionally hears the voices of two men talking about him when no one is around. His roommate states that for the past 2 months the patient has been increasingly withdrawn and ?suspicious. Which of the following is the most likely diagnosis for this patient

Delusional disorder

Schizoaffective disorder

Schizophreniform disorder

Schizophrenia

PCP intoxication

A 20 year old woman is brought to the ER by her family after they were patient, unable to get her to eat or drink anything for the past two days. The although awake, is completely unresponsive both vocally and nonverbally. She actively resists any attempt to be moved. Her family states that for the previous 7 days she has become increasingly withdrawn, socially isolated, and bizarre, often speaking to people no one else could see. Which of the ?following diagnoses is the most likely in this patient

Schizoaffective disorder

Delusional disorder

Schizophreniform disorder

Catatonia

Brief psychotic disorder

the A 40 year old woman is arrested by the police after she is found crawling through window of a movie star's home. She states that the movie star invited her into his home because the two are secretly married and "it just wouldn't be good for his career if everyone knew." The movie star denies the two have ever met, but notes that the woman has sent him hundreds of letters over the past 2 years. The woman has never been in trouble before, and lives an otherwise isolated and unremarkable ?life. Which of the following diagnoses is this patient likely to have

- Delusional disorder
- Schizoaffective disorder
- Bipolar I disorder
- Cyclothymia
- Schizophreniform disorder

!Thank you