

Schizophrenia-like Disorders

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BRIEF PSYCHOTIC DISORDER

- patients who would be considered schizophrenic but disorder lasts only 1 day ÷ 1 month!!!
- typically caused by severe stress in susceptible people (e.g. with preexisting personality disorders).
 - disorder is uncommon.
 - treatment - similar to *acute exacerbation of schizophrenia* (supervision, short-term antipsychotics).

DSM-IV Diagnostic Criteria for Brief Psychotic Disorder:

A. Presence of at least one of following symptoms:

1. **Delusions**
2. **Hallucinations**
3. **Disorganized speech** (e.g. frequent derailment or incoherence)
4. **Grossly disorganized** or **catatonic behavior**

B. Duration - at least 1 day but no more than 1 month, with eventual return to premorbid level of functioning; when diagnosis must be made without waiting for expected recovery, it should be qualified as "provisional"

C. Not better accounted for by **mood disorder** (i.e., no full mood syndrome is present) or **schizophrenia**, and not due to direct effects of **substance** or **general medical condition**.

Specify if:

with marked stressor(s) [brief reactive]: if symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in person's culture.

without marked stressor(s).

with postpartum onset: if onset within 4 weeks' postpartum.

DELUSIONAL DISORDER

- **nonbizarre*** delusions in absence of other mood or psychotic symptoms; **no functional impairment, no cognitive deficits, no negative symptoms!**

***nonbizarre** delusions - *about situations that can occur in real life* (e.g. being followed, being loved, having infection, being deceived by one's spouse); other name for such well systemized, well-organized, relatively consistent delusions is **PARANOIA**.

vs. **bizarre** delusions - clearly implausible, not understandable, not derived from ordinary life experiences (e.g. thought insertion, thought control).

N.B. personal beliefs should be evaluated with great respect to complexity of cultural and religious differences - **some cultures have widely accepted beliefs that may be considered delusional in other cultures!**

DSM-IV-TR criteria for Delusional Disorder:

Criterion A: **nonbizarre delusions** (i.e. involving situations that occur in real life) of at least 1 month's duration.

Criterion B: criterion A for schizophrenia has never been met (i.e. no hallucinations, disorganized speech, negative symptoms, or grossly disorganized behavior) for more than few hours.

Note: *tactile and olfactory hallucinations* may be present in delusional disorder if they are related to delusional theme*.

Criterion C: apart from impact of delusion(s) or its ramifications, **functioning is not markedly impaired**, and behavior is not obviously odd or bizarre.

Criterion D: if **mood episodes** have occurred concurrently with delusions, their total duration has been brief relative to duration of delusional periods.

Criterion E: disturbance is not due to direct physiological effects of **substance** or **general medical condition**.

*e.g. sensation of being infested by insects, perception of body odor

- **mood and affect** are consistent with delusional content, i.e. appropriate emotional response to perceived delusional experiences (e.g. patients with persecutory delusions may be suspicious and anxious); mild dysphoria may be present.
- patient may **act on belief**, but otherwise exhibits no psychotic behavior.

COURSE is relatively stable.

DIAGNOSIS of exclusion.

N.B. 50% patients with **Huntington disease** or **idiopathic basal ganglia calcifications** developed delusions at some point of their illness!

Paranoid personality disorder (extreme suspiciousness) - pervasive distrust begins in early adulthood, patient appears to be unemotional and lacks warmth in relationships (vs. delusional disorder most commonly presents as acute illness of middle life).

SUBTYPES

1. **EROTOMANIC** (s. erotomania, *psychose passionnelle*, Clerambault syndrome, **old maid's insanity**) - *another person, usually of higher status, is in love with patient*; object of delusion is generally perceived as unattainable (e.g. married, belongs to higher social class).
 - patients are generally **female**.
 - delusional love is usually intense in nature.
 - *signs of love denial* by object of delusion are frequently falsely interpreted as affirmation of love.
 - patients may attempt to **contact** object of delusion (phone calls, sending letters and gifts, making visits, even stalking).
 - some cases lead to **assaultive behaviors** (e.g. attempts to pursue object of delusional love; attempts to "rescue" her/him from some imagined danger).
2. **GRANDIOSE** - patients believe that they possess some *great and unrecognized talent*, have made some *important discovery*, have special *relationship with prominent person*, have *special religious insight*.
 - relatively uncommon in absence of mania.

3. **JEALOUS** (s. conjugal paranoia, Othello syndrome, pathological / morbid jealousy) - her / his spouse or lover is unfaithful.
 - some degree of infidelity may occur; however, patients support their accusation with delusional interpretation of "evidence" (e.g. disarrayed clothing, spots on sheets).
 - patients may attempt to confront their spouses.
 - jealousy may evoke **anger** and empower jealous individual with **sense of righteousness** to justify their acts of aggression → **acts of violence** (incl. suicide, homicide).
4. **PERSECUTORY** - patients believe that they are *being persecuted and harmed*.
 - delusions are systematized, coherent, and defended with clear logic.
 - patients are often involved in **formal litigation** against their perceived persecutors.
 - in extreme situations, patients may resort to violence against those who they believe are hurting them.
 - persecutory delusions are common (15-50%) in **Alzheimer** and **other types of dementia**.
5. **SOMATIC** (s. monosymptomatic hypochondriasis) - delusions around *bodily functions and sensations*.
 - most common beliefs: one is infested with insects / parasites, emitting foul odor, body parts are not functioning, body parts are misshapen / ugly.
 - sensory experiences associated with this illness (e.g. sensation of parasites crawling under skin) are viewed as component of delusion.
 - patients are totally convinced in physical nature of this disorder (vs. **hypochondriasis** - patients are usually able to doubt [at least for short while] their convictions of having illness when presented with reassuring data; and fears are usually not limited to single symptom or organ system).
6. **MIXED** - *more than one of delusion simultaneously* (no one delusional theme predominates).
7. **UNSPECIFIED**; examples:
 - CAPGRAS syndrome*** (belief that familiar person has been replaced by identical impostor).
 - FREGOLI syndrome*** (belief that familiar person is disguised as someone else) fall into this category.
 - COTARD syndrome** (belief that patient has lost all their possessions, status, and strength as well as their entire being, including their organs).

*so-called MISIDENTIFICATION SYNDROMES

EPIDEMIOLOGY

- PREVALENCE ≈ 0.03% (vs. schizophrenia ≈ 1%, mood disorders ≈ 5%).
- accounts for 1-2% admissions to inpatient mental health facilities.
- mean **age of onset** - 40 years (ranges 18-90 years).
- **female-to-male** ratio - varies 1.18 ÷ 3:1
 - men** are more likely to develop paranoid delusions;
 - women** are more likely to develop erotomanic delusions.

ETIOLOGY

- unknown.

Genetics

- prevalence of *schizophrenia* in families of patients with delusional disorder ≈ 0.6%.
- *paranoid personality disorder* is common in 1st-degree relatives (4.8%) compared with medical controls (0%) and patients with schizophrenia (0.8%).

Biochemical factors

- conditions involving *basal ganglia* and *temporal lobe* are most commonly associated with delusions.
- hyperdopaminergic states have been implemented.

Psychological factors

- patients selectively attend to available information, make conclusions on basis on insufficient information, attribute negative events to external personal causes, and have difficulty in envisaging other's intentions and motivations.
- patients require less data to make probability decisions compared with normal controls (despite using less data, patients were as certain as controls regarding accuracy of their decisions).
- *PSYCHODYNAMIC THEORIES* suggest that paranoia is **protective response to stress or conflict that represents threat to self-esteem or to self**.

TREATMENT

- **fairly responsive to treatment** (50% patients have symptom-free recovery and 90% patients show at least some improvement).
- **because of poor insight* and impaired judgment regarding their pathology:**
 - *vs. **obsessive-compulsive disorder** - patients show varying degree of insight
 - a) patients rarely seek psychiatric help.
 - b) it is difficult to develop therapeutic alliance (H: avoid direct confrontation of delusional symptoms).
- **hospitalize only** if potential for harm or violence exists.

PSYCHOPHARMACOLOGY

- **polypharmacy** is common (most often antipsychotic + antidepressant).
- a) standard trial of **ANTIPSYCHOTICS** (e.g. **PIMOZIDE** - strongest evidence of response compared with other antipsychotics).
- b) **ANTIDEPRESSANTS** (e.g. SSRI) - successful primarily for **somatic type**.

PSYCHOTHERAPY

- facilitating treatment adherence and providing education about illness and its treatment.
- **social skills training** (e.g. not discussing delusional beliefs in social settings).
- *discussion of unrealistic nature of delusional beliefs* should be done gently and only after rapport with patient has been established.
- **educating family** is also useful (since family frequently feels impact of disorder most).

SHARED PSYCHOTIC DISORDER (s. FOLIE DEUX)

- patient who did not originally have psychotic disorder, develops **shared delusion because of close contact with psychotic person** (such as parent or spouse).

- symptoms diminish with separation from that other person.

SCHIZOPHRENIFORM DISORDER

- **diagnostic criteria for schizophrenia are met, except that symptoms last < 6 months** (but at least > 1 month).
- **majority of patients recover** without residual symptoms.
- few patients eventually meet criteria for schizophrenia.
- **treatment - antipsychotics and supportive psychosocial care.**
 - after symptoms resolve, drug treatment is continued for 12 mo and then gradually tapered.

SCHIZOAFFECTIVE DISORDER

- **two features:**
- 1) **mood episode** (manic or major depressive) **with acute psychotic symptoms** suggestive of schizophrenia.
- 2) **psychotic episode** (at least 2 weeks duration) **without mood symptoms** in individual with previously diagnosed mood disorder ← this distinguishes from *MOOD DISORDER WITH PSYCHOTIC FEATURES*.

DSM-IV Diagnostic Criteria for Schizoaffective Disorder

- Uninterrupted period of illness during which there is major depressive or manic episode concurrent with symptoms that meet criterion A for schizophrenia.
- During same period of illness, there have been delusions or hallucinations for at least 2 weeks in absence of prominent mood symptoms.
- Symptoms meeting criteria for mood episode are present for substantial portion of total duration of active and residual periods of illness.
- Not due to direct effects of substance abuse.

Specify type:

Bipolar type: if manic episode or both manic and major depressive episodes.

Depressive type: if major depressive episode only.

N.B. significant mood symptoms (depressive or manic) are present for substantial portion of total duration of illness, concurrent with symptoms of schizophrenia!

TREATMENT

- combinations of medications used for both schizophrenia and mood disorders (lithium or antidepressants*).
 - *should generally be introduced once positive psychotic symptoms are stabilized; SSRIs are preferred.
 - psychotherapy
 - community support.
- prognosis is better than for schizophrenia but worse than for mood disorders.

SYMBIOTIC PSYCHOSIS

- **parents misperceive themselves as their child**; reciprocal usually is true also.
- in DSM-IV, it is called **PSYCHOTIC DISORDER NOT OTHERWISE SPECIFIED**.
- usually occurs in mothers and their children (fathers occasionally are affected).
- loss of ego boundaries (i.e. inability to distinguish oneself from others) is apparent.
- great anxiety at threat of separation of child from parent is seen in both; upon reuniting, anxiety clears.
- overlap between parent and child can be manifested in almost any area (e.g. if parents diet, they assume that child needs to diet).
- although parent is cause of problem, child usually manifests symptoms (e.g. severe separation anxiety).
- **treatment - psychotherapy** aimed at separating child from parent; in refractory cases, actual separation through out-of-home placement may be necessary.

SUBSTANCE-INDUCED PSYCHOTIC DISORDER

- **psychotic symptoms that begin during or < 1 mo after intoxication** with **or withdrawal** from implicated substance.

Treatment may vary depending on drug involved.

- **hallucinogen** and **phencyclidine** psychosis may not respond well to antipsychotics.
- agitation may respond best to short-acting benzodiazepines (e.g. **LORAZEPAM**).

BIBLIOGRAPHY for ch. "Psychiatry" → follow this [LINK >>](#)