Making the Diagnosis: Psychotic Disorders

Approach: Start with definitions and then work through the diagnostic criteria. Schizoaffective tends to be confusing, so spend some time talking about mood/psychotic symptom overlap. Try to anchor this to patient examples you have. Make sure to focus on the time criteria, which are heavily tested.

Hook: Psychosis is one of the more fascinating parts of psychiatry, and can arise from many different disorders. Understanding diagnostic criteria for these is critical for success on shelf & this inpatient unit.

Content:

***Delusions**:* Fixed false belief. Can be persecutory, referential, grandiose, erotomanic, somatic
Hallucinations: Perception-like experiences that occur without an external stimulus. AH/VH.
Negative Symptoms: diminished emotional expression, avolition (decreased motivated purposeful actions), alogia (diminished speech output), anhedonia, asociality

1. *Substance-Induced Psychotic Disorder*: Presence of delusions and/or hallucinations, developing soon after substance intoxication/withdrawal, not better explained by psychotic disorder. Ex: stimulants, cannabis, opiates, PCP, alcohol/sedative withdrawal
2. *Delusional Disorder*: ***Presence of 1 or more delusion for at least one month***
   Hallucinations are not prominent, if present they are related to the delusional theme. Functioning is not markedly impacted.
3. *Brief Psychotic Disorder:* ***Duration of episode >1 day, <1 month***
   Presence of at least one of: delusions, hallucinations, disorganized speech. With eventual full return to function
4. *Schizophreniform: An episode of* ***at least 1 month but less than 6 months.***
   Two or more, with at last one being: delusions, hallucinations, disorganized speech, +/- grossly disorganized or catatonic behavior, negative symptoms.
5. *Schizophrenia:* Same as schizophreniform but **at least 6 months.** Level of functioning is markedly below level prior to onset.
   - Onset for 1st psychotic episode is early-to-mid-20s for males and late-20s for females.
   - Psychotic symptoms tend to diminish over the life course, perhaps in association with normal age-related declines in dopamine activity. Negative symptoms are more closely related to prognosis than positive sx and tend to be the most persistent.
   - Approximately 5%–6% of individuals with schizophrenia die by suicide, about 20% attempt suicide

What if there is a significant mood component?

6. *Schizoaffective:* An uninterrupted period of illness during which there is a major mood episode (MDD or mania) concurrent with schizophrenia diagnostic features. Must have delusions or hallucinations for 2 weeks in the absence of major mood episode. (*Never mood without psychosis, as opposed to BPAD w/ psychotic features – no psychosis without mood episode)*

General principles of treatment for non-affective psychosis?

1) Antipsychotic medications work fair well for positive but not negative symptoms. Keep very close eye to side effects, which can be quite significant with our current antipsychotic options. Antipsychotics all have relatively similar efficacy apart from Clozaril.
2) Encourage minimization of comorbid substance use
3) Cultivate insight if possible, consider long acting injectable (LAI) early on if it isn't

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