Delusional psychosis and other psychotic disorders

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Other psychotic disorders

1. Brief Reactive Psychosis
2. Schizophreniform Psychosis ("acut schizophrenia")
3. Schizoaffective Psychosis
4. Induced Psychosis
5. "atypical psychosis") post partum psychosis …e.g.

Schizoaffective disorder

- Schizophrenia symptoms and bipolar symptomatology at the same time
- Delusions and hallucinations at least two weeks in the absence of mood symptoms
- Specificy type:
  - Bipolar type (manic or mixed episodes + depr.)
  - Depressive type

History

Kasanin (1933): symptoms of both schizophrenia and mood disorders

- Good premorbid history
- Better prognosis
- Brief psychotic periods
- Often a specific stressors

Epidemiology

- lifetime prevalence: 0.5 to 0.8 percent
- lower in men than in women
- onset at late adolescence or early adulthood

- depressive type of schizoaffective disorder may be more common in older persons
- bipolar type may be more common in young adults

Etiology

- The cause of schizoaffective disorder is unknown

- Distinct disorder or between the schizophrenia-mood disorder continuum
- Marker research is nearer to results on mood disorders although other data also available (DST)
- Heterogeneous
  - schizophrenia with prominent affective symptoms
  - mood disorder with prominent schizophrenic symptoms

DSM Diagnostic Criteria

- Symptoms of sch + major depressive, manic, or a mixed episode
- Mood episodes are present for a substantial portion of the total duration of the illness
- Delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms

Treatment of schizoaffective psychosis

- Acute treatment – depending on the symtomptomatology:
  - Psychosis: antipsychotics
  - Depression: antidepressants (Sertralin) – may precipitate switch to mania
  - Mania: mood stabilizers in higher doses
- Maintenance treatment – lithium, valproat, carbamazepine, antipsychotics, antidepressants
- Cautious clinical approach

Brief psychotic disorder

- Acute and transient psychotic syndrome
- Duration from one day to one month
- Delusions, hallucinations,disorganized speech, catatonia or grossly disorganized behavior
- Importance of stresses – psychogene psychosis, reactive psychosis (Jaspers, 1913)
- The individual returns to the premorbid level of functioning

Epidemiology, etiology

- Not known
- Higher incidence in women and persons in developing countries
- The disorder is often seen in patients with personality disorders (histrionic, narcissistic, paranoid, schizotypal, borderline)
- Personality with biological or psychological vulnerability for the development of psychosis
- Escape from a stressful psychosocial situation

Treatment and prognosis

- Antipsychotics and benzodiazepines
- Psychotherapy: psychological integration of traumas, stresses and psychotic experiences

- Generally good prognosis: 50 to 80 percent of all patients have no further major psychiatric problems

Table 7.5-1
Good Prognostic Features for Brief Psychotic Disorder

Good premorbid adjustment
Few premorbid schizoid traits
Severe precipitating stressor
Sudden onset of symptoms
Affective symptoms
Confusion and perplexity during psychosis
Little affective blunting
Short duration of symptoms
Absence of relatives with schizophrenia

Schizophreniphorm psychosis

- Langfeldt – 1939
  - Sudden onset and benign course
  - Schizophrenia-like symptoms
  - Return to their baseline level of functioning
- Resembles to schizophrenia (symptoms, PFC hypoactivation, enlarged ventricules), but similarities to the episodic nature of mood disorders
- Lifetime prevalence is 0,2 percent

Diagnostic and Clinical Features

- Diagnostic criteria – schizophrenia symptoms at least one month but less then six monhs

- Acute psychotic disorder that has a rapid onset and lacks a long prodromal phase
- Unlikely to report a progressive decline in social and occupational functioning
- Negative symptoms may be present, but relatively uncommon
- Patients return to their baseline state within 6 months
- In some instances, the illness is episodic
- Progression to schizophrenia range between 60 and 80 percent (after the second or third episode)

Treatment

- Antipsychotics
- Patients respond to antipsychotic treatment much more rapidly than patients with sch
- Lithium, carbamazepine, or valproate

- Psychotherapy: help patients integrate the psychotic experience into their understanding of their own minds and lives

Schizotypal personality disorder

Pervasive patterns of peculiar ideation, appearance and behaviour, deficits in interpersonal relatedness (strange, odd behaviour that are not so severe that they can be termed schizophrenic and there is no history of psychotic episodes)

Symptoms: magical thinking, ideas of reference

eccentric behaviour, speech without incoherence

social isolation *(no* close friends)

inadequate rapport in face-to-face situation

Treatment: group therapy (if it is tolerable)

Delusional disorder (Paranoia)

- Delusion: false fixed beliefs not in keeping with the culture
- Non-bizarre delusions (situations that can occur in real life)
- Delusions are connected to the patient's ego and the patient is not able to be influenced to give it up (Jaspers, 1913)
- At least one month duration (DSM-IV)

Epidemiology

- Relativly rare, but may be underreported (rarely seek psychiatric help)
- The prevalence is estimated between 0.025 and 0.03 percent
- Mean age of onset is about 40 years (18-90)
- Slightly more women are affected

Etiology

- The cause is unknown
- Increased prevalence of delusional disorder and related personality traits in families
- Neither an increased incidence of schizophrenia and mood disorders
- May involve the limbic system or basal ganglia (as in neurological conditions)

- Patients are socially isolated and have attained less than expected levels of achievement
- Lack of trust in relationships (overcontrolling mother and a distant or sadistic father)

History

- Kalhbaum – paranoia 1863
- Freud – Schreber case – psychological understanding of paranoid mechanisms
  - role of projection in the formation of delusional thought (defense against unconscious homosexual tendencies)
  - but no higher incidence of homosexual ideation or activity is found
- Cameron – paranoid pseudocommunity (perceived community of plotters - attribution of malevolent motivations to persons)

Table 7.4-1
Risk Factors Associated with Delusional Disorder

Advanced age

Sensory impairment or isolation

Family history

Social isolation

Personality features (e.g., unusual interpersonal sensitivity)

Recent immigration

Table 8–2. DSM-IV diagnostic criteria for delusional disorder

A. Nonbizarre delusion(s) (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, having a disease, being deceived by one's spouse or lover) of at least 1 month's duration.

B. Criterion A for schizophrenia has never been met.[a]

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

C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.

D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.

E. The disturbance is not due to the direct psychological effects of a substance (e.g., drugs of abuse, medication) or a general medical condition.

Diagnosis

- Mental status examination: quite normal except for a markedly abnormal delusional system
- Nonbizarre delusions - at least 1 month's duration
- Tactile and olfactory hallucinations may be present - if they are related to the delusional theme
- Functioning is not markedly impaired and behavior is not obviously odd
- Mood episodes - brief relative to the duration of the delusional periods

Table 7.4-4
Diagnosis and Management of Delusional Disorder

Rule out other causes of paranoid features

Confirm the absence of other psychopathology

Assess consequences of delusion-related behavior

- Demoralization
- Despondency
- Anger, fear
- Depression
- Impact of search for "medical diagnosis," "legal solution," "proof of infidelity," and so on (e.g., financial, legal, personal, occupational)

Assess anxiety and agitation

Assess potential for violence, suicide

Assess need for hospitalization

Institute pharmacological and psychological therapies

Maintain connection through recovery

Symptoms

- Thoughts – key symptom – non-bizarre, usually systematized
- Veracity of a patient's beliefs should be checked
- No insight into their condition

- Mood is consistent with the content of delusion (grandiose - euphoric, persecutory – suspicious)
- No prominent or sustained hallucinations (tactile, olfactory, sometimes auditory)

Subtypes of delusional disorder(DSM-IV)

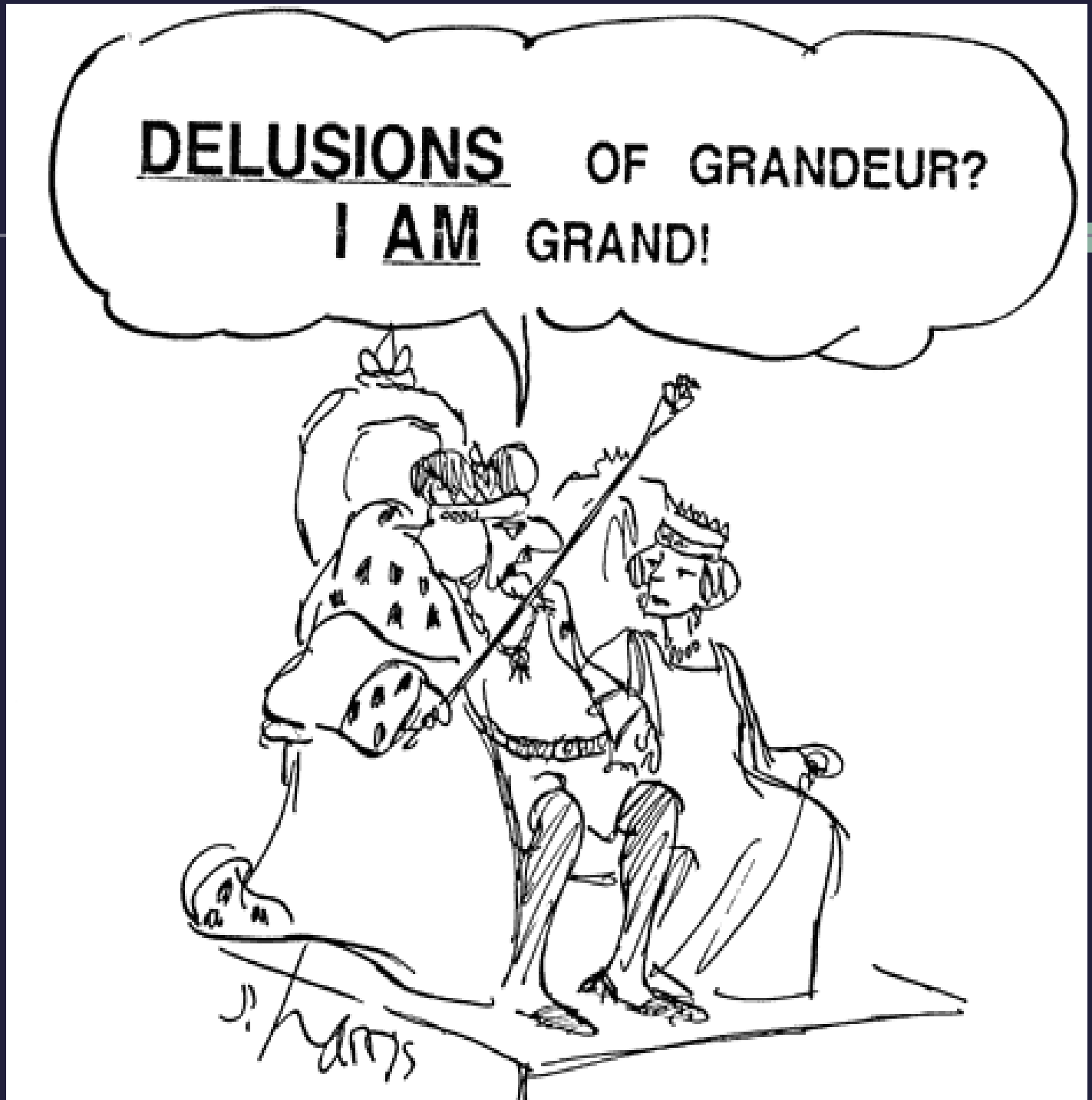
- Persecutory type
- Jealous type (Othello syndrome)
- Erotomanic type (De Clerambault syndrome)
- Grandiose type
- Somatic type (monosymptomatic hypochondrial psychosis)
- Mixed type
- Unspecified type

Erotomanic type (de Clerambault syndrome)

- delusions that another person, usually of higher status, is in love with the individual
- usually women - single and have few sexual contacts
- sometimes men - more aggressive and possibly violent
- *paradoxical conduct* - interpreting all denials of love, no matter how clear, as secret affirmations of love
- rationalizes paradoxical behavior of the object
- object being the first to fall in love
- sudden onset, chronic course

Jealous type (Othello syndrome)

- delusions that the individual's sexual partner is unfaithful
- usually afflicts men
- difficult to treat and may diminish only on separation, divorce
- potentially dangerous (suicide and homicide)


DELUSIONS OF GRANDEUR?
I AM GRAND!

Somatic type
monosymptomatic hypochondriacal psychosis

- delusions that the person has some physical defect or general medical condition
- totally convinced of the physical nature of the disorder

- Rarely present for psychiatric evaluation

1. delusions of infestation (parasitosis, Ekbom syndrome)
2. delusions of dysmorphophobia (misshapenness, personal ugliness, exaggerated size of body parts)
3. delusions of foul body odors (*olfactory reference syndrome)*

- Persecutory type:

  patients convinced that they are being persecuted or harmed

- Grandiose Type (megalomania):

  delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person

- Mixed type:

  delusions characteristic of more than one of the above types but no one theme predominates

Unspecified type

Predominant delusion cannot be subtyped within the previous categories

Delusional misidentification syndromes

- *Capgras syndrome* (illusion of doubles): a familiar person has been replaced by an impostor

- *Frégoli syndrome*: familiar persons can assume the guise of strangers

Treatment of delusional disorder

- 50 percent of patients recover at long-term follow-up, 20 percent show decreased symptoms, and 30 percent exhibit no change.

Psychotherapy

- Individual therapy (insight-oriented, supportive, cognitive, and behavioral)
- Building trustful relationship - neither agree with nor challenge a patient's delusions
- Successful treatment: a satisfactory social adjustment rather than abatement of the patient's delusions

Antipsychotics (low dose, should explain potential adverse effects)

TABLE 1. RELATIVE RECEPTOR AFFINITIES OF ATYPICAL ANTIPSYCHOTIC DRUGS

Drug	D_1	D_2	D_3	D_4	α_1	α_2	H_1	ACh	5-HT_1	5-HT_2	5-HT_{2A}
Clozapine	++	+	?	+	+++	+++	+++	++	+	++	+
Risperidone	+	+++	?	+	+++	+++	+	–	+	–	+++
Olanzapine	++	+++	+	+	++	+	+++	+	–	++	++
Quetiapine	+	++	+	–	+++	+	+++	–	–	+	+++
Aripiprazole	+	++++	?	?	–	–	–	–	++	?	+++
Ziprasidone	++	+++	++	?	++	–	+	–	++	?	+

D=dopamine; α=alpha-adrenergic; H=histamine; ACh=acetylcholine; 5-HT=5-hydroxytryptamine (serotonin); ++++=very high affinity; +++=high affinity; ++=moderate affinity; +=low affinity; –=negligible affinity; ?=unknown affinity.

Adapted from: Ananth J, Parameswaran S, Hara B. *Curr Pharm Des*. 2004;10:2205-2217.

Cañas F. *CNS Spectr*. Vol 10, No 8 (Suppl 10). 2005.

Psychotherapy

- Definition:

Psychological treatment of psychiatric disorders through the establishment of a professional relationship with a patient

Several specific models of psychotherapy (supportive, cognitive, behavioral, dimanic)

- Indication:

Very useful in moderate or chronic depression, bipolar disorder

Synergistic effect in combination with pharmacotherapy

- Limits : Needs the patient's consent

Recommendations for the management of delusional disorder

1. Because the delusional disorder patient is so suspicious, it may be very difficult to establish a therapeutic relationship.
   - Building a relationship will take time and patience.
   - The therapist must neither condemn nor collude in the delusional beliefs of the patient.
   - The patient must be assured of complete confidentiality.
2. Once rapport is established, gently challenge the delusional beliefs, and point ou how they are interfering with the patient's functioning.
   - Tact and skill will be needed to convince the patient to accept treatment.
3. A patient with delusional disorder may be more accepting of medication if it is explained as treatment for the anxiety, dysphoria, and stress that the patient invariably experiences as a result of his or her delusions.
   - Patients with the somatic subtype may preferentially respond to pimozide.
4. Treatment for the jealous subtype may include separation and divorce. Unfortunately, the delusional beliefs of infidelity may transfer to future lovers or spouses.

Shared psychotic disorder

Folie a deux

- A delusion develops in an individual in the context of a close relationship with another person, who has an already-established delusion.
- Dominant or primary patient transfers the delusion to a submissive or recipient patient
- Shared symptomatology – mainly delusions but hallucinations and conversive symptoms were also reported
- Separation of patients , hospitalisation, antipychotics

Culture bound syndromes

Present themselves preferentially in particular sociocultural contexts

- Amok (Malaysia): outburst of agressive behavior, amnesia, exhaustion
- Koro (East Asia): anxiety that the penis will recede into the body, and possibly cause death
- Piblokto (Eskimos): extreme excitement up to 30 minutes, convulsive seizures and coma lasting up to 12 hours
- Witigo: psychosis among indians that they will transform into witigo, a giant monster

Thank you for your attention!