PSYCHCEs

# An Introduction to Severe Psychopathology

# Introduction

Psychotic disorders are mental disorders in which a person's personality is severely confused to the point where the individual loses touch with reality. When a psychotic episode occurs, a person becomes unsure about what is real and what is not real and usually experiences hallucinations, delusions, off-the-wall behavior, disorganized speech, and incoherency. While schizophrenia is the most common psychotic disorder, several other disorders can cause psychotic symptoms.

# Schizophrenia

## Characteristics

Schizophrenia is a serious mental disorder in which people interpret reality abnormally. Schizophrenia may result in a combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning and that can be disabling. People with schizophrenia require lifelong treatment. However, early treatment may help get symptoms under control before serious complications develop and may help improve the long-term outlook (Mayo Clinic, 2022).



Schizophrenia is a chronic brain disorder that affects less than one percent of the U.S. population. When schizophrenia is active, symptoms can include delusions, hallucinations, disorganized speech, trouble with thinking, and lack of motivation. However, with treatment, most symptoms of schizophrenia will significantly improve, and the likelihood of a recurrence can be diminished.

While there is no cure for schizophrenia, research is ongoing to find innovative and safer treatments. Experts are also unraveling the disease's causes by studying genetics, conducting behavioral research, and using advanced imaging to look at the brain's structure and function. These approaches hold the promise of new and more effective therapies.

The complexity of schizophrenia may help explain why there are misconceptions about the disease. Schizophrenia does not mean split personality or multiple-personality. Most people with schizophrenia are no more dangerous or violent than people in the general population. While limited mental health resources in the community may lead to homelessness and frequent hospitalizations, it is a misconception that people with

schizophrenia end up homeless or living in hospitals. Most people with schizophrenia live with their families, in group homes, or on their own (American Psychiatry Association, 2020).

## Prevalence

Schizophrenia is estimated in 2020 to affect 1.1 percent of the population or approximately 2.8 million adults in the United States aged 18 or older. In addition, an estimated 40 percent of individuals with the condition are untreated in any given year (Treatment Advocacy Center, 2022).

Research has shown that schizophrenia affects men and women fairly equally but may have an earlier onset in males. Rates are similar around the world. People with schizophrenia are more likely to die younger than the general population, largely because of high rates of co-occurring medical conditions, such as heart disease and diabetes. Symptoms of schizophrenia usually first appear in early adulthood and must persist for at least six months for a diagnosis to be made. Men often experience initial symptoms in their late teens or early 20s, while women show first signs of the illness in their 20s and early 30s. More subtle signs may be present earlier, including troubled relationships, poor school performance, and reduced motivation. (American Psychiatry Association, 2020).



## Symptoms

**Psychotic symptoms** include changes in how a person thinks, acts, and experiences the world. People with psychotic symptoms may lose a shared sense of reality with others and experience the world in a distorted way. For some people, these symptoms come and go. For others, the symptoms become stable over time. Psychotic symptoms include (NIMH, 2021):

- **Hallucinations:** When a person sees, hears, smells, tastes, or feels things that are not actually there. Hearing voices is common for people with schizophrenia. People who hear voices may hear them for a long time before family or friends notice a problem.
- **Delusions:** When a person has strong beliefs that are not true and may seem irrational to others. For example, individuals experiencing delusions may believe that people on the radio and television are sending special messages that require

a certain response, or they may believe that they are in danger or that others are trying to hurt them.

- **Thought disorder:** When a person has ways of thinking that are unusual or illogical. People with thought disorders may have trouble organizing their thoughts and speech. Sometimes a person will stop talking in the middle of a thought, jump from topic to topic, or make up words that have no meaning.
- **Movement disorder:** When a person exhibits abnormal body movements. People with a movement disorder may repeat certain motions over and over.

**Negative symptoms** include loss of motivation, loss of interest or enjoyment in daily activities, withdrawal from social life, difficulty showing emotions, and difficulty functioning normally. Negative symptoms include (NIMH, 2021):

- Having trouble planning and sticking with activities, such as grocery shopping
- Having trouble anticipating and feeling pleasure in everyday life
- Talking in a dull voice and showing limited facial expression
- Avoiding social interaction or interacting in socially awkward ways
- Having very low energy and spending a lot of time in passive activities.



These symptoms are sometimes mistaken for symptoms of depression or other mental illnesses.

**Cognitive symptoms** include problems with attention, concentration, and memory. These symptoms can make it hard to follow a conversation, learn new things, or remember appointments. A person's level of cognitive functioning is one of the best predictors of their day-to-day functioning. Cognitive symptoms include (NIMH, 2021):

- Having trouble processing information to make decisions
- Having trouble using information immediately after learning it
- Having trouble focusing or paying attention

## Diagnosis

Although there are numerous abnormalities in the brain structure and function of individuals with schizophrenia, no single condition can be tested or measured to produce a definitive diagnosis. Without such measures, the disease is diagnosed by its symptoms. The following are the diagnostic criteria from the DSM-5 (2013):

Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganized Speech
4. Grossly disorganized or catatonic behavior
5. Negative symptoms

AND

For a significant portion of the time since the onset of the disturbance, the level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset.



AND

Continuous signs of the disturbance persist for at least six months. This 6-month period must include at least one month of symptoms (or less if successfully treated).

AND

The disturbance is not attributed to other psychological disorders, medical conditions, or substances.

## Treatment

Antipsychotic medications can help make psychotic symptoms less intense and less frequent. These medications are usually taken every day in a pill or liquid form. Some antipsychotic medications are given as injections once or twice a month. People respond to antipsychotic medications in different ways. Therefore, it is important to report any side effects to a healthcare provider. Many people taking antipsychotic medications

experience side effects such as weight gain, dry mouth, restlessness, and drowsiness when they start taking these medications. Some of these side effects may go away over time, while others may last (NIMH, 2021).

Psychosocial treatments help people find solutions to everyday challenges and manage symptoms while attending school, working, and forming relationships. These treatments are often used together with antipsychotic medication. People who participate in regular psychosocial treatment are less likely to have symptoms reoccur or to be hospitalized. Examples of this kind of treatment include cognitive behavioral therapy, behavioral skills training, supported employment, and cognitive remediation interventions (NIMH, 2021).

Educational programs can help family and friends learn about symptoms of schizophrenia, treatment options, and strategies for helping loved ones with the illness. In addition, these programs can help friends and family manage their distress, boost their own coping skills, and strengthen their ability to provide support (NIMH, 2021).

Coordinated specialty care (CSC) programs are recovery-focused programs for people with first-episode psychosis, an early stage of schizophrenia. Health professionals and specialists work together as a team to provide CSC, which includes psychotherapy, medication, case management, employment and education support, and family education and support. The treatment team works collaboratively with the individual to make treatment decisions, involving family members as much as possible. Compared with typical care, CSC is more effective in reducing symptoms, improving quality of life, and increasing involvement in work or school.

Assertive community treatment (ACT) is designed to help individuals with schizophrenia who are likely to experience multiple hospitalizations or homelessness. ACT is generally delivered by a team of health professionals and specialists who work together to provide care to patients in the community (NIMH, 2021).

It is common for people with schizophrenia to have problems with drugs and alcohol. Therefore, a treatment program that includes treatment for both schizophrenia and substance use is important for recovery because substance use can interfere with treatment for schizophrenia (NIMH, 2021).

## Prognosis

While there is currently no known cure for schizophrenia, the prognosis has improved through increased research and improved treatment modalities.

Ten years after diagnosis (WebMD, 2021):

- 50% of people with schizophrenia are either recovered or improved to the point that they can work and live on their own.
- 25% are better but need help from a strong support network to get by.
- 15% are not better. Most of these are in the hospital.
- The amount of time from the start of symptoms to diagnosis and treatment. Once symptoms begin, the sooner you're treated for schizophrenia, the more likely you are to improve and recover. But prodrome -- the time between when symptoms begin and full psychosis starts -- can be days, weeks, or even years. The average length of time between the start of psychosis and the first treatment is 6 to 7 years

## Causes

Several factors may contribute to a person's risk of developing schizophrenia, including (NIMH, 2021):

- **Genetics.** Schizophrenia sometimes runs in families. However, just because one family member has schizophrenia, it does not mean that other family members will also have it. Studies suggest that many different genes may increase a person's chances of developing schizophrenia but that no single gene causes the disorder by itself.
- **Environment.** Research suggests that a combination of genetic factors and aspects of a person's environment and life experiences may play a role in the development of schizophrenia. These environmental factors may include living in poverty, stressful or dangerous surroundings, and exposure to viruses or nutritional problems before birth.
- **Brain structure and function.** Research shows that people with schizophrenia may be more likely to have differences in the size of certain brain areas and connections between brain areas. Some of these brain differences may develop before birth. Researchers are working to better understand how brain structure and function may relate to schizophrenia.

# Schizoaffective Disorder

## Characteristics

Schizoaffective disorder is a mental health disorder marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania.

The two types of schizoaffective disorder — both of which include some symptoms of schizophrenia — are (Mayo Clinic, 2022):

- **Bipolar type:** which includes episodes of mania and sometimes major depression
- **Depressive type:** which includes only major depressive episodes (Mayo Clinic, 2022)

## Prevalence

Schizoaffective is relatively rare, with a lifetime prevalence of only 0.3%. Men and women experience schizoaffective disorder at the same rate, but men often develop the illness at an earlier age. Schizoaffective disorder can be managed effectively with medication and therapy. However, co-occurring substance use disorders are a serious risk and require integrated treatment (NAMI, 2022).

## Symptoms

The symptoms of schizoaffective disorder can be severe and need to be monitored closely. In addition, depending on the type of mood disorder diagnosed, depression or bipolar disorder, people will experience different symptoms (NAMI, 2022):

- Hallucinations are seeing or hearing things that aren't there.
- Delusions are false, fixed beliefs that are held regardless of contradictory evidence.
- Disorganized thinking. A person may quickly switch from one topic to another or provide completely unrelated answers.

- Depressed mood. If individuals have been diagnosed with schizoaffective disorder depressive type, they will experience feelings of sadness, emptiness, feelings of worthlessness, or other symptoms of depression.
- Manic behavior. A person who has been diagnosed with schizoaffective disorder: bipolar type, will experience feelings of euphoria, racing thoughts, increased risky behavior, and other symptoms of mania.

## Diagnosis

The following is the diagnostic criteria from the DSM-V (2013):

Two or more of the following presentations, each present for a significant amount of time during a 1-month period (or less if successfully treated). At least one of these must be from the first three below.

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g., frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (i.e., diminished emotional expression or avolition.)



AND

Hallucinations and delusions for two or more weeks in the absence of a major mood episode (manic or depressive) during the entire lifetime duration of the illness.

AND

Symptoms that meet the criteria for a major mood episode are present for most of the total duration of both the active and residual portions of the illness.

**Bipolar type:** includes episodes of mania and sometimes major depression.

**Depressive type:** includes only major depressive episodes.

AND

The disturbance is not the result of the effects of a substance (e.g., a drug of misuse or a medication) or another underlying medical condition.

## Treatment

People with schizoaffective disorder generally respond best to a combination of medications, psychotherapy, and life skills training. Treatment varies depending on the type and severity of symptoms and whether the disorder is the depressive or bipolar type. In some cases, hospitalization may be needed. However, long-term treatment can help to manage the symptoms. Such treatment includes (Mayo Clinic, 2022):

**Medications.** In general, doctors prescribe medications for schizoaffective disorder to relieve psychotic symptoms, stabilize mood and treat depression. These medications may include:

- **Antipsychotics.** The only medication approved by the Food and Drug Administration specifically for treating schizoaffective disorder is the antipsychotic drug paliperidone (Invega). However, doctors may prescribe other antipsychotic drugs to help manage psychotic symptoms such as delusions and hallucinations.
- **Mood-stabilizing medications.** When the schizoaffective disorder is bipolar type, mood stabilizers can help level out the mania highs and depression lows.
- **Antidepressants.** When depression is the underlying mood disorder, antidepressants can help manage feelings of sadness, hopelessness, or difficulty with sleep and concentration.

**Psychotherapy.** In addition to medication, psychotherapy may help. Psychotherapeutic interventions may include:

- **Individual therapy.** Psychotherapy may help to normalize thought patterns and reduce symptoms. In addition, building a trusting relationship in therapy can help people with schizoaffective disorder better understand their condition and learn to manage symptoms. Effective sessions focus on real-life plans, problems, relationships, and coping strategies.
- **Family or group therapy.** Treatment can be more effective when people with schizoaffective disorder are able to discuss their real-life problems with others. Supportive group settings can also help reduce social isolation, provide a reality

check during periods of psychosis, increase appropriate use of medications and develop better social skills.

**Life skills training.** Learning social and vocational skills can help reduce isolation and improve quality of life.

**Social skills training.** This focuses on improving communication and social interactions and improving the ability to participate in daily activities. In addition, new skills and behaviors specific to settings such as the home or workplace can be practiced.

**Vocational rehabilitation and supported employment.** This focuses on helping people with schizoaffective disorder prepare for, find and keep jobs.

**Hospitalization.** During crisis periods or times of severe symptoms, hospitalization may be necessary to ensure safety, proper nutrition, adequate sleep, and basic personal care.

**Electroconvulsive therapy.** For adults with schizoaffective disorder who do not respond to psychotherapy or medications, electroconvulsive therapy (ECT) may be considered.

## Prognosis

While there is no cure for schizophreniform disorder with treatment, 50% of patients have seen positive results. Favorable results are defined as minimal or no symptoms and/or employment. These outcomes were highly reliant on the early initiation of treatment and optimized treatment regimens as outlined above.

Left untreated, schizoaffective disorder has many ramifications on both social functioning and activities of daily living. These include unemployment, isolation, impaired ability to care for self, etc. Untreated mental disorders have more than just social and functional consequences. Some studies show that as many as 5% of people with a psychotic illness will die by suicide. Research has shown that among all completed suicides, ten percent are attributable to those with a psychotic illness (Wy & Saadabadi, 2021).

## Causes

The exact cause of schizoaffective disorder is unknown. However, a combination of causes may contribute to the development of schizoaffective disorder (NAMI, 2022).

- **Genetics.** Schizoaffective disorder tends to run in families. This does not mean that you will get it if a relative has an illness. But it does mean that there is a greater chance of you developing the illness.
- **Brain chemistry and structure.** Brain function and structure may be different in ways that science is only beginning to understand. Brain scans are helping to advance research in this area.
- **Stress.** Stressful events such as a death in the family, the end of a marriage, or the loss of a job can trigger symptoms or an onset of the illness.
- **Drug use.** Psychoactive drugs such as LSD have been linked to the development of schizoaffective disorder.

# Schizophreniform Disorder

## Characteristics

Schizophreniform disorder is a type of psychotic illness with symptoms similar to those of schizophrenia but lasting for less than six months. Like schizophrenia, schizophreniform disorder is a type of psychosis in which a person cannot tell what is real from what is imagined. It also affects how people think, act, express emotions, and relate to others. If symptoms last longer than six months, doctors consider the person to have schizophrenia rather than schizophreniform disorder (WebMD, 2020).

## Prevalence

About one person in 1,000 develops schizophreniform disorder during his or her lifetime. The disorder occurs equally in men and women between the ages of 18 and 24. However, it often strikes men at a younger age. In women, it most often occurs between the ages of 24 and 35 (Cleveland Clinic, 2022).

## Symptoms

Schizophreniform disorder is characterized by symptoms identical to those of schizophrenia but that last at least one month but less than six months. If the duration

of symptoms exceeds six months, the patient no longer meets the required diagnostic criteria for schizophreniform disorder, and the diagnosis is likely to be schizophrenia (Tamminga, 2022).

## Diagnosis

The following are the diagnostic criteria from the DSM-5 (2013):

Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. delusions
2. hallucinations
3. disorganized speech (e.g., frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior
5. negative symptoms (i.e., diminished emotional expression or avolition)

AND

An episode of the disorder lasts at least one month but less than six months.

AND

The disturbance is not attributed to other psychological disorders, medical conditions, or substances.

## Treatment

Treatment with antipsychotics and supportive psychosocial care is indicated. After symptoms resolve, drug treatment is continued for 12 months and then gradually tapered while closely monitoring for the return of psychotic symptoms (Tamminga, 2022).

## Prognosis

Based on the criteria for schizophreniform, people will recover in 6 months or less.

# Brief Psychotic Disorder

## Characteristics

The essential feature of brief psychotic disorder is sudden onset (a change from nonpsychotic state to a clear psychotic state within 2 weeks), the disturbance lasts for less than a month and there is a return to previous level of functioning (DSM-5, 2013). Preexisting personality disorders (e.g., paranoid, histrionic, narcissistic, schizotypal, borderline), as well as certain medical conditions (e.g., systemic lupus, steroid ingestion), predispose to its development. In addition, a major stressor, such as the loss of a loved one, may precipitate the disorder (Tamminga, 2022).

## Prevalence

In the United States, brief psychotic disorder may account for 9% of cases of first-onset psychosis and it is twice as likely to occur in females than males (DSM-5, 2013).



## Symptoms

Patients with the disorder manifest at least one psychotic symptom for less than one month (Tamminga, 2022):

- Delusions
- Hallucinations
- Disorganized speech
- Grossly disorganized or catatonic behavior

## Diagnosis

The following are the diagnostic criteria from the DSM-5 (2013):

Presence of one (or more) of the following symptoms. At least one of these must be (1), (2), or (3):

1. delusions

2. hallucinations
3. disorganized speech (e.g., frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior

AND

The duration of an episode of the disturbance is at least one day but less than one month, with an eventual full return to the premorbid level of functioning.

AND

The disturbance is not attributed to other psychological disorders, medical conditions, or substances.

### Treatment

Treatment recommendations are similar to other psychotic disorders to include a combination of antipsychotic drugs, psychotherapy, and community support programs as needed.



### Prognosis

Patients will recover in 1 month or less. Relapse is common, but patients typically function well between episodes and have few or no symptoms (Tamminga, 2022).

## Delusional Disorder

### Characteristics

Delusional disorder is characterized by firmly held false beliefs (delusions) that persist for at least one month, without other symptoms of psychosis (Tamminga, 2022). Delusions are distinguished from mistaken beliefs in that delusional beliefs remain unchanged in the face of clear, reasonable evidence to the contrary; this distinction is sometimes difficult to make when the beliefs are more plausible (e.g., that a spouse is unfaithful). Delusional disorder is distinguished from schizophrenia by the presence of

delusions without any other symptoms of psychosis (e.g., hallucinations, disorganized speech or behavior, negative symptoms). The delusions may be (Tamminga, 2022):

- **Nonbizarre:** They involve situations that could occur, such as being followed, poisoned, infected, loved at a distance, or deceived by one's spouse or lover.
- **Bizarre:** They involve implausible situations, such as believing that someone removed their internal organs without leaving a scar.

## Prevalence

Delusional disorder is relatively uncommon. Onset generally occurs in middle or late adult life. Psychosocial functioning is not as impaired as it is in schizophrenia, and impairments usually arise directly from the delusional belief. When delusional disorder occurs in older patients, it is sometimes called paraphrenia. It may coexist with mild dementia. Therefore, the physician must be careful to distinguish delusions from elder abuse being reported by a mildly demented older patient (Tamminga, 2022).



## Symptoms

Early symptoms may include the feeling of being exploited, preoccupation with the loyalty or trustworthiness of friends, a tendency to read threatening meanings into benign remarks or events, a persistent bearing of grudges, and a readiness to respond to perceived slights.

Several **subtypes of delusional disorder** are recognized (Tamminga, 2022):

- **Erotomanic:** Patients believe that another person is in love with them. Efforts to contact the object of the delusion through telephone calls, letters, surveillance, or stalking are common. People with this subtype may have conflicts with the law related to this behavior.
- **Grandiose:** Patients believe they have a great talent or have made an important discovery.
- **Jealous:** Patients believe that their spouse or lover is unfaithful. This belief is based on incorrect inferences supported by dubious evidence. They may resort to physical assault.

- **Persecutory:** Patients believe they are being plotted against, spied on, maligned, or harassed. They may repeatedly attempt to obtain justice through appeals to courts and other government agencies and may resort to violence in retaliation for the imagined persecution.
- **Somatic:** The delusion relates to a bodily function; e.g., patients believe they have a physical deformity, odor, or parasite.

Patients' behavior is not obviously bizarre or odd. Apart from the possible consequences of their delusions (e.g., social isolation or stigmatization, marital or work difficulties), patients' functioning is not markedly impaired.

## Diagnosis

The following are the diagnostic criteria from the DSM-V (2013):

The presence of one (or more) delusions with a duration of 1 month or longer.

AND

Criterion A for schizophrenia has never been met. Hallucinations, if present, are not prominent and are related to the delusion theme.

AND

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

AND

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

AND

The disturbance is not attributed to other psychological disorders, medical conditions, or substances.

## Treatment

Treatment aims to establish an effective physician-patient relationship and manage complications. A substantial lack of insight is a challenge to treatment. If patients are assessed to be dangerous, hospitalization may be required. Insufficient data are available to support the use of any particular drug, although antipsychotics sometimes suppress symptoms. A long-term treatment goal of shifting the patient's major area of concern away from the delusional locus to a more constructive and gratifying area is difficult but reasonable (Tamminga, 2022).

### Prognosis

A delusional disorder does not usually lead to severe impairment or change in personality, but delusional concerns may gradually progress. However, most patients can remain employed as long as their work does not involve things related to their delusions (Tamminga, 2022).

## Substance or Medication Induced Psychotic Disorder



### Characteristics

Substance- or medication-induced psychotic disorder is characterized by hallucinations and/or delusions due to the direct effects of a substance or withdrawal from a substance. Episodes of substance-induced psychosis are common in emergency departments and crisis centers. There are many precipitating substances, including alcohol, amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidine (PCP), and sedative/hypnotics. To be considered substance-induced psychosis, the hallucinations and delusions should be in excess of those that typically accompany simple substance intoxication or withdrawal, although the patient may also be intoxicated or withdrawing (Tamminga, 2022).

### Prevalence

Between 7%-25% of individuals presenting with a first episode of psychosis are reported to have substance/medication-induced psychotic disorder. It is typically severely disabling and consequently is observed most frequently in emergency rooms, as individuals are often brought to the acute-care setting when it occurs.  However the

disability is typically self-limited and resolves upon removal of the offending agent (DSM-5, 2013).

## Symptoms

Symptoms are often brief, resolving shortly after the causative drug is cleared, but psychosis triggered by amphetamines, cocaine, or PCP may persist for many weeks. Because some young people with prodromal or early-stage schizophrenia use substances that can induce psychosis, it is important to obtain a thorough history, particularly to seek evidence of prior mental symptoms, before concluding that acute psychosis is due solely to substance use (Tamminga, 2022).

## Diagnosis

The following are the diagnostic criteria from the DSM-V (2013):

Presence of one or both of the following symptoms:

1. Delusions
2. Hallucinations

AND



There is evidence from the history, physical examination, or laboratory findings that either (1) or (2):

1. the symptoms in Criterion A developed during, or within a month of, substance intoxication or withdrawal
2. medication used is etiologically related to the disturbance

AND

The disturbance is not better accounted for by a psychotic disorder that is not substance induced. Evidence that the symptoms are better accounted for by a psychotic disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication, or are substantially in excess of what would be expected given the type or

amount of the substance used or the duration of use; or there is other evidence that suggests the existence of an independent non substance-induced psychotic disorder (e.g., a history of recurrent non substance-related episodes).

AND

The disturbance does not occur exclusively during the course of delirium.

AND

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

## Treatment

- A calm environment
- Often a benzodiazepine or antipsychotic

In most substance-induced psychoses, stopping the substance and giving an anxiolytic (e.g., a benzodiazepine) or antipsychotic drug is effective.

For psychosis, due to dopamine-stimulating drugs such as amphetamine, an antipsychotic drug is most effective.

For psychosis due to drugs such as lysergic acid diethylamide (LSD), quiet observation may be all that is needed.

For substances with actions that do not involve dopamine, observation may be all that is needed, or an anxiolytic may help (Tamminga, 2022).

## Prognosis

While the psychosis typically resolves once the causative drug has been eliminated from the individual's system there are situations where the psychosis persists. Agents such as amphetamines, phencyclidine, and cocaine have been reported to evoke temporary psychotic states that can sometimes persist for weeks or longer despite removal of the agent and treatment with neuroleptic medication.  In later life, polypharmacy for medical conditions and exposure to medications for parkinsonsism, cardiovascular disease, and other medical disorders may may be associated with a greater likelihood of

psychotic induced by prescription medications as opposed to substance of abuse (DSM-5, 2013)

## Other Psychotic Disorders

### Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorders that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders class. The unspecified schizophrenia spectrum and other psychotic disorder category are used in situations in which the clinician chooses *not* to communicate the specific reason that the presentation does not meet the criteria for any specific schizophrenia spectrum or psychotic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., emergency room settings) (DSM-5, 2013).



### Other Specified Schizophrenia Spectrum and Other Psychotic Disorder

This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorders that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders class. In addition, the other specified schizophrenia spectrum and other psychotic disorder categories are used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific schizophrenia spectrum and other psychotic disorder. This is done by recording "other specified schizophrenia spectrum and other psychotic disorder" followed by the specific reason (e.g., persistent auditory hallucinations) (DSM-5, 2013).

## Research Pertaining to Psychotic Disorders

## Additional Risk Factors

Persons with psychotic disorders are at risk for complications and derivative effects of psychosis, particularly suicide attempts (lifetime prevalence, 34.5%), substance abuse (lifetime prevalence, 74%), homelessness (annual prevalence, 5%), victimization by others (prevalence over a 3-year period, 38%), and committing acts of violence (increase in the odds of violence, as compared with the general population, 49 to 68%) (Leiberman & First, 2018).

## Causes of Psychosis

Experts contend that there is no one specific cause of psychosis. As discussed previously, psychosis may be a symptom of a mental illness, such as schizophrenia or bipolar disorder. However, a person may experience psychosis and never be diagnosed with schizophrenia or any other mental disorder. There are other causes, such as sleep deprivation, general medical conditions, certain prescription medications, and the misuse of alcohol or other drugs (NIMH, 2021).

Other considerations in the causation of psychosis include (Lieberman & First, 2018):

**Neurotransmitters in Psychosis:** As a consequence of their pathology, many disorders that have different causes and pathophysiological characteristics have altered neurotransmission in the dopamine and glutamate pathways of the hippocampus, midbrain, and corpus striatum, and prefrontal cortex, which leads to the emergence of psychotic symptoms.

**Genetic Factors in Psychosis:** Epidemiologic studies strongly implicate heredity in the pathogenesis of the idiopathic psychotic disorders. Schizophrenia and bipolar disorder with psychotic symptoms are characterized by approximately 50% concordance of certain genetic loci between identical twins, and among the siblings and parents of persons with an idiopathic psychotic disorder, rates of the same disorder are 10 to 15 times as high as the rates in the general population. The specific genetic markers and modes of heritance of psychotic disorders have not been determined.

**Neurodevelopmental Factors in Psychosis:** Exposure to prenatal environmental insults (e.g., maternal infections, drug toxicity, and nutritional deficiencies), birth complications, postnatal trauma, and other forms of deprivation at critical stages of development are associated with a risk of subsequent psychotic disorders. Although

their effect sizes are small, these environmental factors are thought to interact with genetic factors and increase susceptibility to psychotic disorders.

**Autoimmune and Inflammatory Disorders with Psychosis:** A special category of psychoses consists of those that develop with autoimmune and inflammatory disorders, in which autoantibodies stimulate or block neurotransmitter function in the brain. Psychotic symptoms occur in association with autoimmune diseases that have nervous system manifestations, especially Systemic Lupus Erythematosus.

### Best Practices

In patients with psychotic disorders who are in the early stages of illness, treatment at the first episode of schizophrenia or schizoaffective disorder shortens the duration of psychotic episodes, reduces recurrences, and limits progressive decline in intellectual and functional capacity over the course of the patient's life. Based on these observations, a structured service model for the first episodes of psychosis, Coordinated Specialty Care, has been developed to improve the clinical benefits of treatment. This model of care includes pharmacotherapy, psychosocial therapies (including those for substance abuse), and public outreach to promote the identification of and reduction in the duration of untreated psychotic symptoms (Leiberman & First, 2018).



### Additional Treatments

Brain-stimulation techniques, such as electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), transcranial direct-current stimulation (tDCS), and deep-brain stimulation (DBS), have been used for psychotic symptoms in specific disorders. For example, ECT is effective for catatonia and mood disorders with psychotic symptoms and is indicated in patients with schizophrenia or schizoaffective disorders when symptoms are unresponsive to antipsychotic medications. DBS, the most invasive of the neuromodulation techniques, has been used for psychotic states when all other treatments have failed. The procedure entails surgically implanting an electrode into target brain regions and stimulating them with high-frequency electrical pulses (Leiberman & First, 2018).

## Conclusion

All psychotic disorders have symptoms in at least one of the following areas: delusions, hallucinations, disorganized thinking, abnormal behavior, and negative symptoms. Depending on the onset, duration, and severity will determine the diagnosis of a particular psychotic disorder. Current research has found that early assessment, diagnosis and treatment lead to the highest success rates (depending on diagnosis, this may mean full recovery and return to pre-diagnosis functioning, or management of symptoms to increase level of functioning in the community). Monitoring a person's safety is critical during a psychotic episode, particularly when consideration is given to the high suicide rate. While there are a number of predispositions that may lead to one person being more likely to be diagnosed with a psychotic disorder, more research is still needed to fully understand psychotic disorders and find successful treatment modalities.

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