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Psychiatry and Addictions Case Conference
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Diagnosing Psychotic Disorders in Primary Care

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SPEAKER DISCLOSURES

✔ Nothing to disclose

PLANNER DISCLOSURES

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LEARNING OBJECTIVES

1. Review DSM-5-TR criteria, diagnosis, and overview of treatment for psychotic disorders
2. Describe common psychiatric diagnoses with symptoms that may overlap with or mimic psychosis
3. Develop strategies to differentiate psychotic symptoms and diagnoses for comorbid, complex, or ambiguous clinical cases
4. Apply this information when consulting with providers and staff from other specialties

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DSM-5-TR: Schizophrenia Spectrum and Other Psychotic Disorders

Positive Symptoms:

- Delusions- fixed beliefs not amenable to change with convincing evidence
- Hallucinations- perception-like experiences occurring without an external stimulus
- Disorganized or Abnormal Motor Behavior:
  - psychomotor agitation
  - inability to complete daily tasks
- Disorganized thinking- inferred from disorganized speech:
  - derailment
  - loose association
  - tangentiality
  - word salad

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DSM-5-TR: Schizophrenia Spectrum and Other Psychotic Disorders

Other possible features:

- **Catatonia**
  - negativism- resisting instructions
  - inappropriate posturing
  - no verbal (mutism) or motor (stupor) responses
  - purposeless/excessive motor activity (catatonic excitement)
  - echolalia
  - staring
  - grimacing
  - stereotyped movements
- **Cognitive Changes**
  - memory
  - concentration

DSM-5-TR: Schizophrenia Spectrum and Other Psychotic Disorders

Negative Symptoms:

- Most commonly associated with schizophrenia* vs. other psychotic disorders

- Diminished emotional expression*
- Avolition*- decrease in self-motivated, purposeful activities
- Alogia- diminished speech output
- Anhedonia- decreased ability to experience pleasure from positive stimuli
- Asociality- lack of interest in social interactions

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Differential Diagnoses- Psychotic Disorders

- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Delusional Disorder

- Substance/Medication-Induced Psychotic Disorder

Differential Diagnoses: Schizophrenia Spectrum and Other Psychotic Disorders

Diagnosis:	**Brief Psychotic Disorder**	**Schizophreniform Disorder**	**Schizophrenia**
Positive Symptom Requirement*	>1	>2	>2
Negative Symptom Requirement	None	None	**Yes**
Timeline	< 1 month, then **returns to premorbid functioning**	1-6 months	> 6 months

*ONE symptom must be **delusions** or **hallucinations**,

Disorganized speech may count for brief psychotic d/o only

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Additional Diagnostic Criteria

Schizophrenia

- 2 or more positive symptoms for at least one month
- 6 or more months of disturbance may include **negative or attenuated symptoms**
- Includes disturbance of function in major life areas (work, relationships, self-care) **without return to premorbid functioning**
- ***Average age-of-onset: 13.78-29.28 years**
  - Increased severity of symptoms with earlier age-of-onset

*Musket CW, Kuo SS, Rupert PE, et al. Why does age of onset predict clinical severity in schizophrenia? A multiplex extended pedigree study. *Am J Med Genet Part B*. 2020; 183B: 403–411. https://doi.org/10.1002/ajmg.b.32814

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Diagnostic Criteria

Schizoaffective Disorder

- Major mood episode (depressive or manic) **concurrent with** schizophrenia symptoms AND
- >2 weeks of delusions or hallucinations **without** mood symptoms

Case Example #1:

65 y.o. female, hx of complex PTSD, alcohol use d/o (in sustained remission), and GAD. Significant recent stressors regarding relationship with daughter. Presents to BHIP psychiatry for management of anxiety. During interview, mentions stress related to parasitic infection on face. Has done own skin scrapings and examined under microscope at home. Chart review and conversation with PCP shows diagnosis of seborrheic dermatitis. Pt reports recently leaving dermatologist after he “called me crazy” for these concerns, hesitant to establish care with new dermatologist after this experience. PCP reports low concern for parasitic infection though recently prescribed PO ivermectin after insistence from patient.

Diagnostic Criteria

Delusional Disorder

- 1 (or more) delusional beliefs without prominent hallucinations
- >1 month
- Baseline occupational functioning remains intact

- **Subtypes:** erotomaniac (love), grandiose, jealous, persecutory*, somatic (includes parasitosis)

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Prevalence

Diagnosis	Brief Psychotic Disorder	Schizophreniform Disorder	Schizophrenia	Schizoaffective Disorder	Delusional Disorder
Lifetime Prevalence	**2-7%**	similar to schizophrenia	**0.3-0.7%**	0.3%	0.2%
Other Statistics & Risk Factors		may be 5x **less** common in high-income countries	increased prevalence among some migration/ refugee groups **Association with significant social and occupational dysfunction**	more common in women Social and occupational **dysfunction is NOT diagnostic criteria** (unlike schizophrenia)	

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Assessment/Work Up

Assessment:

- MSE
- Full psychiatric interview (as is possible)
- Rule out substance use or medical causes
- Assess for safety and care needs
- Involve psychiatry when needed

Work Up For All New Psychosis:

- Vitals, height/ weight, BMI
- BMP
- CBC
- Lipid panel
- Urine pregnancy test (if indicated)

Work Up Considerations (case by case):

- Hepatic function panel
- TSH
- Syphilis screen
- B12 level
- ESR and/or ANA
- UA
- UDS
- HIV antibody

Ultimately a clinical diagnosis, Scales/screeners exist but less commonly used in practice

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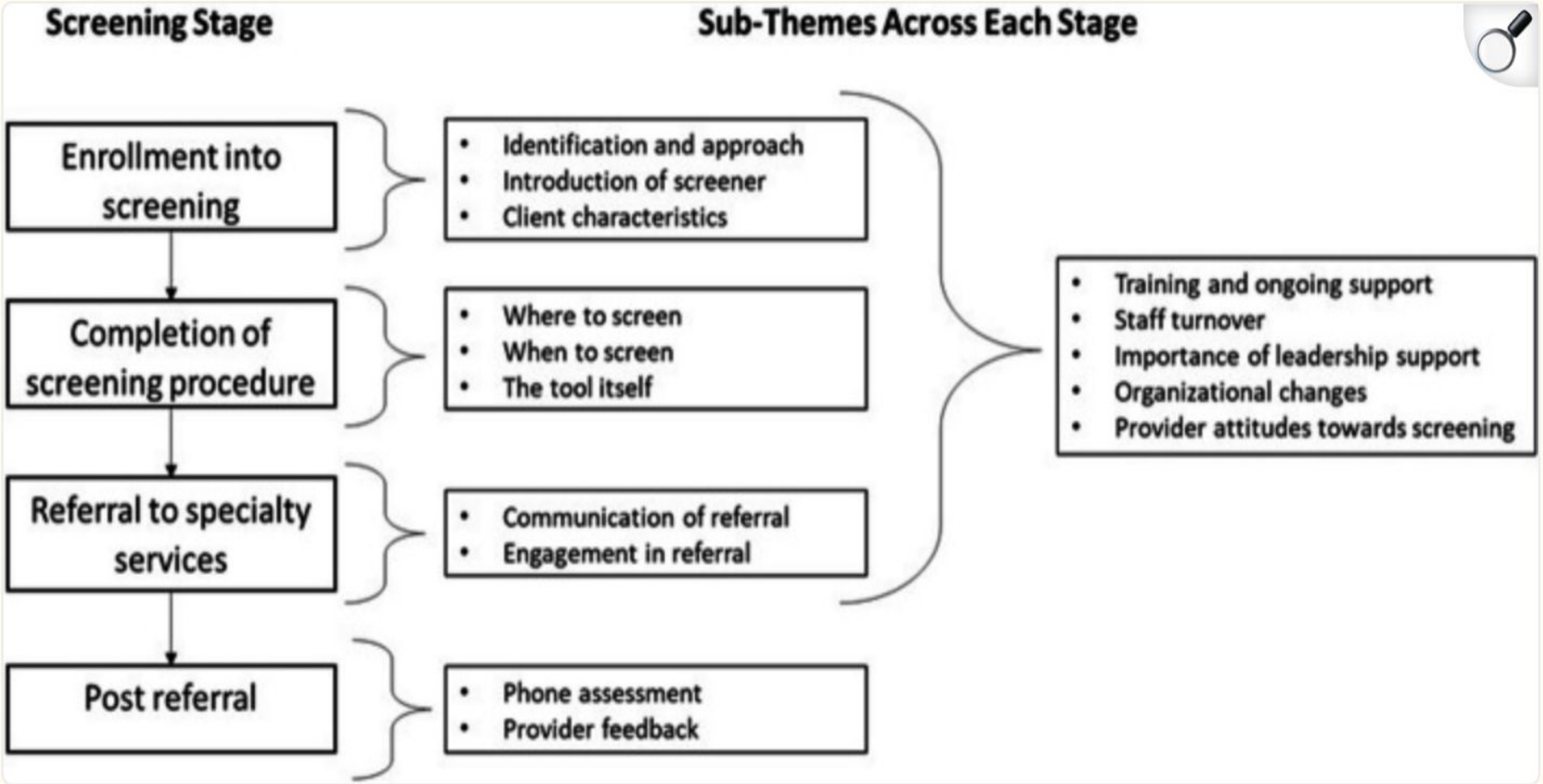
“Exploring the acceptability, barriers, and facilitators to psychosis screening in the integrated behavioral health primary care setting: a qualitative study” (2024)

- Methods: Qualitative interview study (12 providers + 8 service users)
- Takeaway: Good idea but logistics more complicated (who, when, how, etc.)



Savill M, Loewy RL, Gobrial S, et al. Exploring the acceptability, barriers, and facilitators to psychosis screening in the integrated behavioral health primary care setting: a qualitative study. *BMC Health Serv Res*. 2024;24(1):924. Published 2024 Aug 13. doi:10.1186/s12913-024-11359-4

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Diagnostic Hints

Diagnosis	Brief Psychotic Disorder	Schizo-phreniform Disorder	Schizophrenia	Schizoaffective Disorder	Delusional Disorder
Mental Status Exam Clues	rapid MSE changes and resolution	elements of brief psychosis and schizo-phrenia	symptoms <u>persist throughout visits</u>, - Negative symptoms -Notable functional impairment -Disorganization of speech and thought	Schizophrenia criteria <u>AND</u> evidence of major mood episode	-High baseline functioning -Ongoing fixation on delusional topic -Delusion persists despite clear evidence against -Possible defensiveness
Other Diagnostic Clues			Difficult to diagnose in one visit *without* additional collateral and/or documentation	Difficult to diagnose in one visit *without* additional collateral and/or documentation	If health-based delusion, may have seen multiple providers with rejection of providers' assessments/recs

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Treatment Overview

- **Antipsychotics** for initial presentation of psychosis
  - Treat even if official diagnosis still unclear and/or medical work-up is pending
  - EXCEPTIONS: Use benzodiazepines for CNS stimulant intoxication and catatonia
- Treat other underlying medical and/or psychiatric diagnoses
- Psychosocial Interventions
  - CBT
  - Social Skills Training
  - Family Interventions

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Antipsychotic Monitoring

Risk factor	Baseline	Initial monitoring			Long-term monitoring	
		4 weeks	8 weeks	12 weeks	Quarterly	Annually
Personal or family history (diabetes, hypertension, or cardiovascular disease)	X					X
Weight (body mass index)	X	X	X	X	X	
Waist circumference	X			X		X
Blood pressure	X			X	X	
Fasting glucose or HbA1c*	X			X		X
Fasting lipid profile	X	¶		X		X

* HbA1c is usually more practical to obtain than fasting glucose, but either can be used.

¶ For patients taking olanzapine, quetiapine, clozapine.

Also **AIMS every 3-6 months** (based on pt and specific medication)

Differential Diagnoses: Bipolar and Related Disorders

Bipolar I disorder- Mania

- Abnormally "elevated, expansive, or irritable mood" for >**7** days AND
- >3 manic symptoms
  - grandiosity
  - sleep disturbance
  - pressured speech
  - Flight of ideas*
  - Distractibility
  - Psychomotor agitation*, increased goal-directed activity
  - Excessive/risky behaviors
- MAY include positive psychotic features that resolve after episode
- Absence of concurrent negative symptoms during mania
- Manic episode **severe impairment** in social and occupational functioning
- In primary care, may screen for bipolar d/o using **CIDI screening scale**

Differential Diagnoses: Bipolar and Related Disorders

Bipolar II disorder- Hypomania

- Abnormally “elevated, expansive, or irritable mood” for >4 days AND
- >3 manic symptoms
- **No severe impairment** in social and occupational functioning
- Does NOT include (positive) psychotic features

Mania or Hypomania with Mixed Features:

- Episode **+** >3 depressive symptoms for majority of episode
- MAY include positive psychotic features for mania

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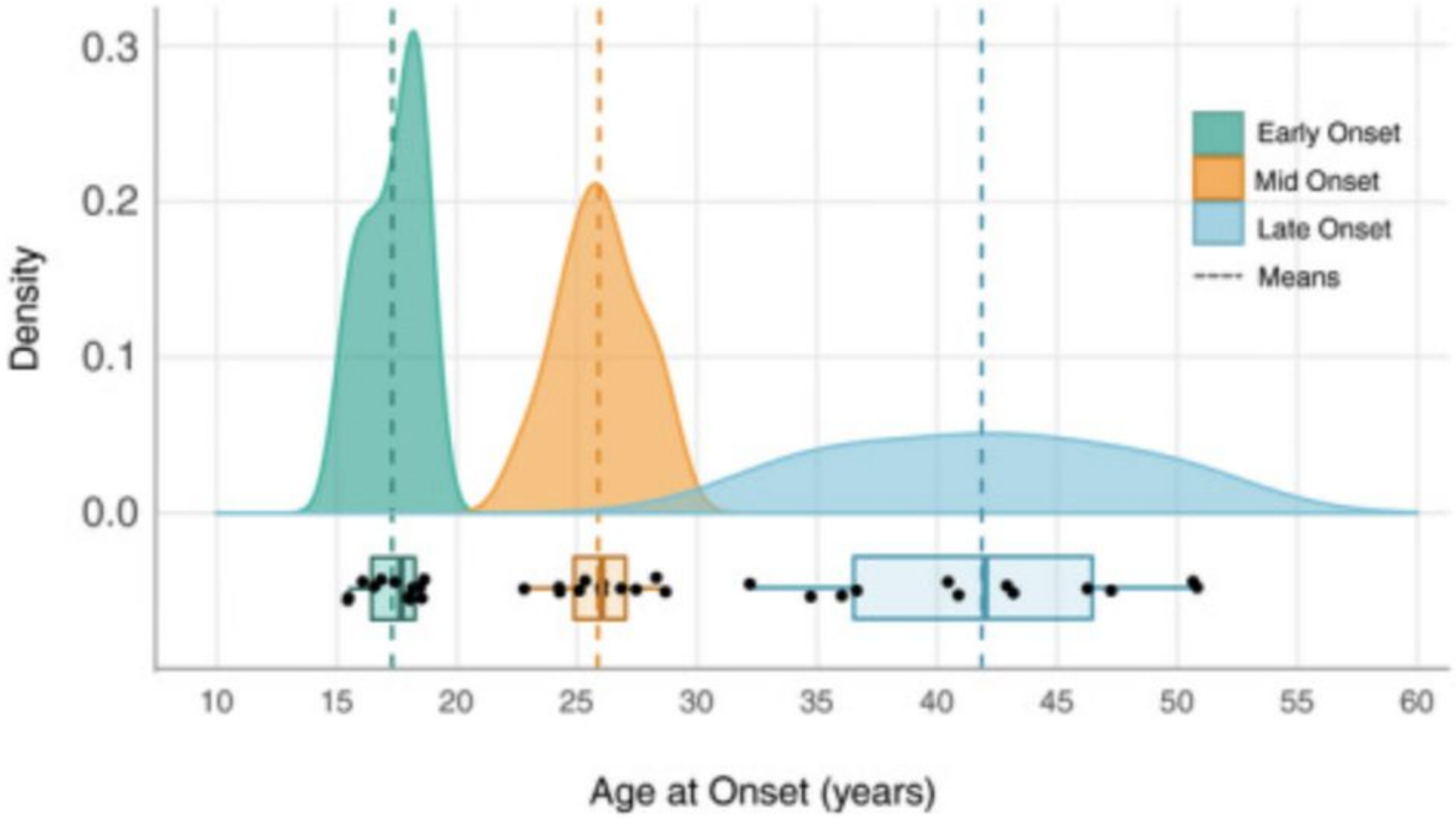
“Bipolar disorder: Trimodal age-at-onset distribution” (2020)

- Methods: Systematic review to investigate age-at-onset (AAO) distribution models for bipolar disorder
- 21 final articles: 14 trimodal, 5 bimodal, 2 other
- Trimodal distribution model more accurate and inclusive
- **Early (14-21): 45%,** avg 17.3
- **Mid: 35%**, avg 26.0
- **Late (>40): 20%,** avg 41.9



Bolton S, Warner J, Harriss E, Geddes J, Saunders KEA. Bipolar disorder: Trimodal age-at-onset distribution. *Bipolar Disord*. 2021;23(4):341-356. doi:10.1111/bdi.13016

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Differential Diagnoses: Depressive Disorders

Major Depressive Disorder

- >5 symptoms of SIGECAPS
- >2 weeks
- MDD with psychotic features:
  - delusions
  - hallucinations
  - **Psychotic features <u>only</u> occur during MDE** which distinguishes this from schizoaffective disorder

Common Differential Diagnoses: Prevalence

Diagnosis	Bipolar I Disorder	Bipolar II Disorder	MDD with psychotic features
Prevalence	12-month US: **1.5%** (2017) 12-month global: **0-0.6%** (2011)	12-month US: **0.8%** (2011) 12-month global: **0.3%** (2011)	12-month US: **7%** (MDD overall)
Other Statistics	equal rates in men and women >likelihood in high-income countries		**2x** higher rates in women, 30% recovery in 3 months, 80% recover in 12 months
Functional Impairment	-**functional recovery may lag behind resolution of mood episode** -**30%** with ongoing dysfunction between episodes (ex work) -Cognitive impairment symptoms during mood episodes *and* euthymia	-majority return to baseline between episodes -15% with some dysfunction between -20% transition directly into next mood episode	**<u>If psychotic features present</u>:** -lower recovery rate -?first episode of bipolar disorder -?transition to schizophrenia

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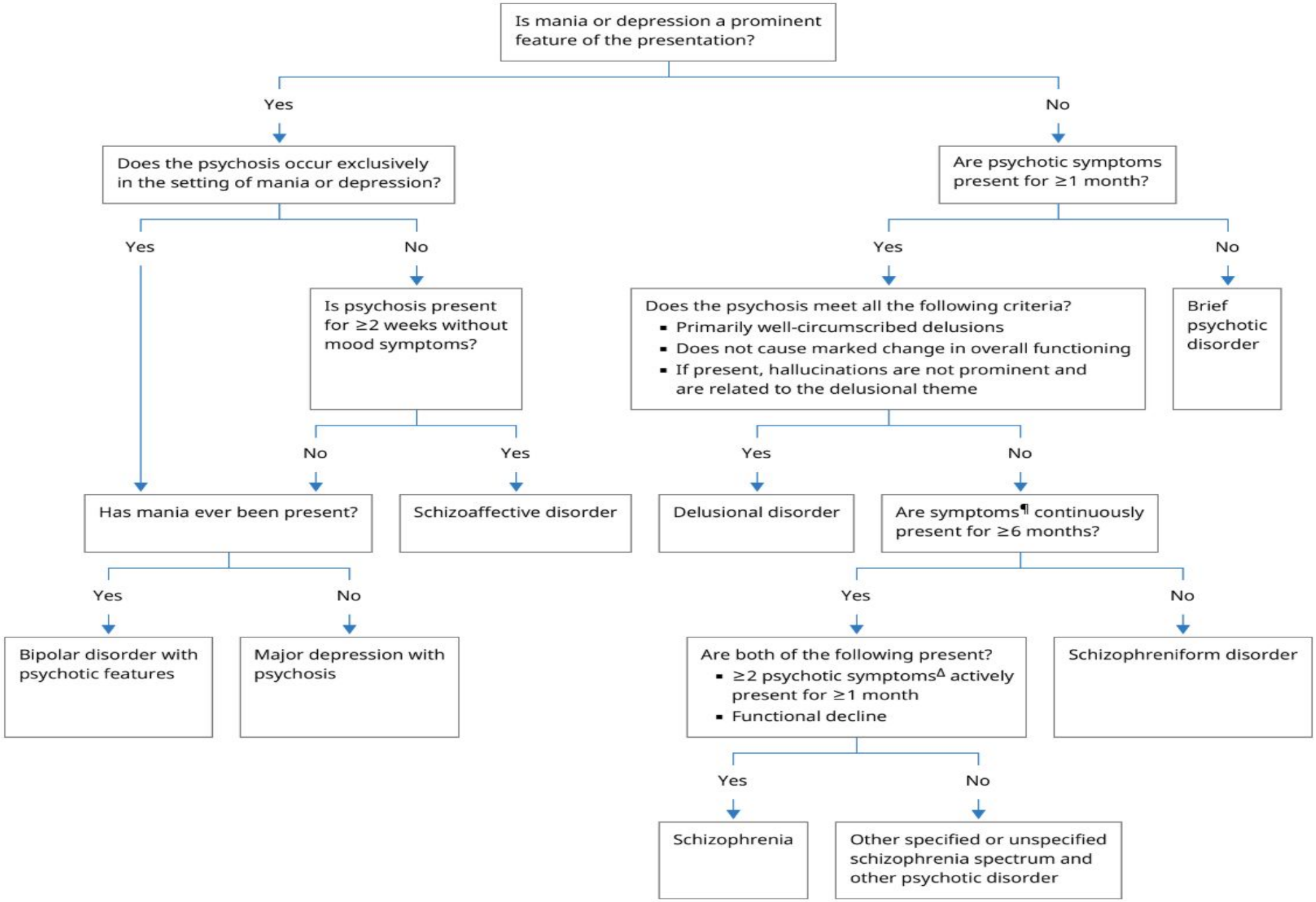
Expanded Differential Workflow:



“Racial Implicit Associations in Psychiatric Diagnosis, Treatment, and Compliance Expectations” (2022)

Methods: Participants completed online demographic questions and 3 race Implicit Association Tests (IATs) related to psychiatric diagnosis (psychosis vs. mood disorders), patient compliance (compliance vs. non-compliance), and psychiatric medications (antipsychotics vs. antidepressants). Linear and logistic regression models were used to identify demographic predictors of racial implicit associations.

Results: The authors analyzed data from 294 medical students and psychiatric physicians. Participants were more likely to pair faces of Black individuals with words related to psychotic disorders (as opposed to mood disorders), non-compliance (as opposed to compliance), and antipsychotic medications (as opposed to antidepressant medications). Among participants, self-reported White race and higher level of training were the strongest predictors of associating faces of Black individuals with psychotic disorders, even after adjusting for participant age.

“Racial Implicit Associations in Psychiatric Diagnosis, Treatment, and Compliance Expectations” (2022)

Londono Tobon A, Flores JM, Taylor JH, et al. Racial Implicit Associations in Psychiatric Diagnosis, Treatment, and Compliance Expectations [published correction appears in Acad Psychiatry. 2021 Aug;45(4):533-534. doi: 10.1007/s40596-021-01435-w.]. *Acad Psychiatry*. 2021;45(1):23-33. doi:10.1007/s40596-020-01370-2

“Race bias and gender bias in the diagnosis of psychological disorders” (2021)

Racial bias: conduct, antisocial, substance+mood comorbidity, eating disorders, PTSD, differential diagnosis of **schizophrenia** and **psychotic affective disorders**

Gender bias: ASD, ADHD, conduct, antisocial, histrionic personality disorder

Garb HN. Race bias and gender bias in the diagnosis of psychological disorders. *Clin Psychol Rev*. 2021;90:102087. doi:10.1016/j.cpr.2021.102087

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Case Example #2:

35 y.o. female G1P1 (one month postpartum) with hx bipolar I disorder that has been well-controlled overall since initial diagnosis and hospitalization at age 25. Brought to ED by husband after one week of escalating behavioral change and paranoia. Newborn son also present in ED. During interview, pt refuses to put baby down or let husband hold him, reports that husband is out to kill their baby and that baby is not safe with anyone but her. Husband reports pt unable to care for son given level of disorganization. MSE positive for rapid speech, PMA (pacing throughout interview), flight of ideas, and persecutory delusions. When inpatient admission is discussed, pt reports that it is a plot so husband can kidnap their son and disappear with him.

Perinatal Considerations

- **Peripartum psychosis/mania:**
  - "with peripartum onset" = first 4 weeks postpartum
  - **Hx of Bipolar (I) d/o is a risk factor for postpartum psychosis**
  - Risk or recurrence with prior postpartum psychosis: **30%-50%**
  - **Psychiatric emergency** due to acute safety risk for parent (suicide) and baby (infanticide- rare)

- **Peripartum depression:**
  - MDE between conception and birth: 9%
  - MDE between birth and 12 months: 7%
  - Psychosis as part of postpartum MDE: **0.2%-0.4%**

Case Example #3:

44 y.o. male with hx of depression and alcohol use disorder (in sustained remission for 10 years). Presents to PCP with new onset symptoms of social withdrawal and low motivation causing functional impairment. Called the clinic requesting appointment with hyperverbal and tangential speech noted. Appears mildly disheveled on MSE with decreased grooming compared to baseline. Pt ensure PCP he has not taken any new medications or used any illicit substances, including alcohol. PCP refers to BHIP Psychiatry for evaluation of new onset psychosis vs bipolar disorder.

Upon interview with psychiatry, pt admits to relapsing on alcohol two weeks prior after experiencing significant familial stressors.

Differential Diagnosis: Substance/Medication-Induced Psychotic Disorder

- Psychotic symptoms (delusions or hallucinations) developed within reasonable timeline of exposure to or withdrawal from illicit substance or prescribed medication
- Substance or medication is capable of producing presenting symptoms

- Prevalence: **7-25%** of first episode psychosis is secondary to substance or medication use
- Evaluate chronological timeline of substance use and symptom onset/remission

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Differential Diagnoses: Substance Use and Psychosis

Intoxication:

- Alcohol
- Cannabis
- PCP
- Inhalants
- Hallucinogens
- Stimulants
- Sedatives/hypnotics/ anxiolytics

Withdrawal:

- Alcohol
- Sedatives/hypnotics/ anxiolytics

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Differential Diagnoses: Substance Use and Bipolar Disorder

Intoxication:

- Alcohol
- PCP
- Hallucinogens
- Stimulants
- Sedatives/hypnotics/ anxiolytics

Withdrawal:

- Alcohol
- Sedatives/hypnotics/ anxiolytics
- Stimulants

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Differential Diagnoses: Prescribed Medication Use and Psychosis

- **Corticosteroids**
- **Anticholinergic medications**
- **Antiparkinsonian medications**
- **Antimicrobials / antivirals**
- **Cardiac medications**
  - Digoxin
  - Beta blockers
- **Over-the-counter medications**

May occur **with or without** prior psychosis history

Consider cautious use for those with psychosis or bipolar d/o hx

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Other Differential Diagnoses:

- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Personality Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Neurodevelopmental Disorders
- Neurocognitive Disorders
- Somatic Symptom and Related Disorders
- Disruptive, Impulsive-Control, and Conduct Disorders

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Case Example #4:

25 y.o. female with hx of depression and anxiety who presents to establish care with new PCP. Recently moved to the area for work as a consultant, first job after graduating MBA program last year. Describes job as extremely overwhelming with additional stressor including grandmother undergoing cancer treatment on the east coast. On interview, reports to PCP sleeping for 3 hours/night and feelings of restless energy throughout the day with difficulty focusing on work tasks. Feels fatigued throughout the day but still has trouble falling asleep due to rumination and other anxious thoughts. No recent change in thought content, impulsive behavior, or grandiosity. PCP notes increased speech rate and fidgeting on exam. Refers to psychiatry to rule out bipolar disorder.

Differential Diagnoses: Anxiety Disorders

Diagnosis:	Overlapping Symptom(s)	Why Not Psychosis?	Prevalence
Separation Anxiety Disorder	Hallucinations/ misperceptions during high stress separation from attachment figure(s)	Resolves when reunited with attachment figure, Symptoms not present outside of times of high stress	children: 4% adolescents: 1.6% **adults: 0.9-1.9%**
Panic Attacks/ Panic Disorder	Experienced paresthesias, fear of "going crazy", derealization (reality), depersonalization (self), impending feelings of doom	Resolves outside of high anxiety/panic attack episodes, high likelihood of anxiety disorder comorbidity	**Panic attacks:** **9.5%-11.2%** (12-month) 13.2% (lifetime) **Panic Disorder:** 2%-3% (12-month) 1.7% (lifetime global)
Generalized Anxiety Disorder	Decreased sleep, psychomotor agitation, subclinical panic symptoms, cognitive difficulty (ex focus)	Correlates with times of anxiety, resolves when anxiety resolves, likely overlap with high stress experiences and anxiety triggers	12-month US: **2.9%** 12-month global: 1.3%:

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Case Example #5:

32 y.o. male with hx of anxiety who presents for psychiatry evaluation. Works as a pediatric hospitalist in a busy practice though recently went on medical leave for mental health concerns. On interview, he states that leave was 2/2 ongoing, severely distressing worry that he has sexually abused his patients. Although he has no clear memory of doing so, he worries that he has but is "forgetting". Has considered turning himself into the police though has not due to a lack of evidence. Married with 14 m.o. son at home, has stopped caring for his son completely over the past few months due to similar concerns. Primary care doctor increasingly concerned for psychosis. Wife initially supportive though is starting to question whether pt actually did commit this abuse given his ongoing distress and perseveration.

Differential Diagnoses: Obsessive Compulsive Disorders

Diagnosis:	Overlapping Symptom(s)	Why Not Psychosis?	Prevalence
Obsessive Compulsive Disorder	Obsessions and compulsions with atypical thought processes and behaviors Specifier: **"with absent insight/delusional beliefs"**	Prominent obsessions + compulsions occurring to rid self of intrusive thought(s), **temporary relief of anxiety which ultimately reoccurs, ego-dystonic,** absence of negative symptoms	12-month US: **1.2%**, similar internationally
Body Dysmorphic Disorder	Repetitive Behaviors: skin picking, excessive grooming Specifier: **"with absent insight/delusional beliefs"**	absence of negative symptoms, organized overall outside of body dysmorphia concerns	2.4% (point prevalence), similar among men and women
Hoarding Disorder	Behavioral changes, loss of social function Specifier: **"with absent insight/delusional beliefs"**	absence of negative symptoms, social isolation/embarrassment lacks global disorganization	Limited data, appx 2.5% internationally, similar among men and women
Trichotillo-mania and Excoriation (skin- picking) Disorder	Atypical behavior (skin picking, hair pulling), May appear disorganized during events	In psychosis, hair pulling/skin picking is **in response to** hallucinations or delusions, **would not give OCD-related diagnosis in this case**	Trichotillomania: 1-2% (12-month) Excoriation d/o: 2.1% current, 3.1% lifetime

Perinatal Considerations

- **Postpartum OCD:**
  - New onset OR exacerbation
  - Often aggressive obsessions of causing violent harm to infant
  - May stop caring for infant (bathing, feeding, holding) due to fear of harm
  - Interferes with parent-infant relationship and bonding
  - **Ego-dystonic,** those experiencing postpartum OCD statistically *less* likely to violently harm infant
  - **Do <u>not</u> report to CPS** if definitively OCD
    - However, CPS may be a resource for additional support if needed
    - Focus on infant care needs and parental support/treatment in the acute period

Case Example #6:

58 y.o. female with hx of depression, anxiety, PTSD, bipolar disorder, and schizophrenia. Has tried multiple psychiatric medications of various classes in the past with a high rate of side effects and only partial efficacy. Describes mood as “all over the place”. Hx of multiple traumatic experiences + chronic familial/caregiver dysfunction throughout childhood. Episodes of AH and feeling “outside of my body” briefly during times of high stress. Hx of self-harm behavior and suicidality requiring inpatient psychiatric admission, generally triggered by external events/stressors. Mood changes “a lot” with pt sometimes experiencing decreased need for sleep but never for more than one day. Difficulty managing heightened emotions has lead to functional difficulty at work and in relationships.

Differential Diagnoses: Personality Disorders

Diagnosis:	Overlapping Symptom(s)	Why Not Psychosis?	Prevalence
Cluster B: Borderline Personality Disorder	Stress-related paranoia, hallucinations, dissociation Unstable Identity Affective Instability May present as hypomania/mania	"Psychotic" symptoms worsen during times of high stress with return to baseline, Generally organized though interpersonal difficulties likely chronic mood/affective instability <u>without distinct episodes</u>	Primary care: **6%** Outpatient mental health: **10%** Inpatient mental health: **20%**
Cluster A: Paranoid, Schizoid, Schizotypal	Paranoia, Social isolation, Atypical behaviors or beliefs	Present outside of schizophrenia course, depressive episode, or bipolar episode If Cluster A diagnosis precedes schizophrenia diagnosis, specified as "premorbid"	Cluster A combined: median **3.6%** across countries

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Differential Diagnoses: Trauma- and Stressor-Related Disorders

Diagnosis:	Overlapping Symptom(s)	Why Not Psychosis?	Prevalence
PTSD	**Flashbacks:** overlap with hallucinations and perceptual disturbances **Derealization:** detachment from reality **Depersonalization:** detachment from self **Behavioral Change(s)** **Complex PTSD:** hallucinations/paranoia during times of high stress	"Psychotic" symptoms worsen during times of high stress with return to baseline, Requires identifiable traumatic event(s), Generally organized on presentation	U.S. lifetime: **6.8%** (adults) U.S. lifetime: **5.0%-8.1%** (adolescents)
Acute Stress Disorder	As above with limited time course (3-30 days)	As above	w/o interpersonal assault: **<20%** WITH interpersonal assault: **19%-50%**
Grief and Bereavement Disorders	May involve hallucinations (ex loved one's hand on shoulder) or transient perceptions of loved one's presence	Symptoms specific to loss, resolves as (acute) grief resolves	adjustment d/o: **5-20%** prolonged grief: unknown, **9.8%** (estimated 6-month)

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Differential Diagnoses: Dissociative Disorders

Diagnosis:	Overlapping Symptom(s)	Why Not Psychosis?	Prevalence
Dissociative Identity Disorder	Transient psychotic episodes Auditory hallucinations "Intrusion into personality states" and "sudden thought disappearance" overlap with thought insertion and thought broadcasting	"ego alien"/frightening experiences vs delusional belief(s) to explain symptoms Hallucinations outside of auditory or visual may occur in DID	US 12-month: 1.5% US 12-month (Dissociative amnesia): 1.8%
Depersonalization Disorder	Feelings of disconnection from self, **Nihilistic delusions: "I am dead", "I am not real"**	intact reality testing	unknown, **transient experience: 50%** (US lifetime)
Derealization Disorder	Feelings of disconnection from world, **Nihilistic delusions: "The world is not real"**	intact reality testing	unknown, **transient experience: 50%** (US lifetime)

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Case Example #7:

Pt is an 18 y.o. transgender male (AFAB, he/him) with hx of PTSD, depression, and anxiety referred to BHIP psychiatry for evaluation of bipolar d/o after reporting symptoms of decreased need for sleep and hallucinations during recent PCP visit. On interview with psychiatry, pt reports seeing “cats or shadows” briefly at times, worse under times of stress. Some paranoia relating to “people hurting me” though this is largely 2/2 hx of physical/emotional abuse by bio father and bullying throughout school. May become “hyperfixated” on preferred activities (ex video games) leading to decreased need for sleep, when asked to specify timeline pt states “like one day”. States that interest in starting projects and energy level may be increased for a few days at a time though sleep is unchanged. Pt and family have suspected an ASD diagnosis though has never been formally evaluated or diagnosed.

Differential Diagnoses: Neurodevelopmental Disorders

Diagnosis:	Overlapping Symptom(s)	Why Not Psychosis?	Prevalence
Autism Spectrum Disorder	Social-emotional reciprocity deficits, limited facial expressions/non-verbal communication, sterotyped movement, unusual perseverations/preoccupations, unusual Beliefs	Present for <u>all</u> of life, No delusions or hallucinations (not part of diagnostic criteria for ASD), **may answer questions concretely, possibly confused for psychotic symptoms**	US: 1-2% Similar in children and adults, **underdiagnosed in girls/women, underdiagnosed in minoritized communities**
ADHD	Distractibility, impulsivity, rapid speech/thoughts, disorganization, tangentiality, psychomotor agitation, hyperfocus, mood lability	Persistent symptoms, occur without other symptoms of mania (grandiosity, elevated mood), daily mood lability without distinct episodes	children (worldwide): 7.2% adults: 2.5% **underdiagnosed in girls/women, higher prevalence in foster system and correctional settings**
Specific Learning Disorder(s)	Cognitive processing difficulties	Present for <u>all</u> of life, consistent without rapid decline	worldwide: 5-15%

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Case Example #8:

Pt is a 62 y.o. woman, previously healthy, with ongoing ICU admission >2 months. Initially admitted for routine GI procedure with unexpected post-op complications leading to NG tube placement and additional complications involving other organ systems over time. Pt unable to ambulate currently. Neurology previously consulted with diagnosis of delirium given. This morning, pt appeared distressed and insisted that “my daughters are dead” with this worry persisting even after reassurance that the team had talked to them earlier that day. Psychiatry consulted due to concern for new onset psychosis.

Differential Diagnoses: Neurocognitive Disorders

Diagnosis:	Overlapping Symptom(s)	Why Not Psychosis?	Prevalence
Delirium	Hallucinations, delusions, agitation, disturbance of language/ communication, emerging cognitive deficits **Specifier: "with psychotic disturbance"**	Generally occurs 2/2 underlying medical illness and/or prolonged hospitalization, symptoms expected to resolve upon illness improvement and normalization of environment, **waxing and waning course**	Overall: 1-2% In ED: 8-17% At hosp admission: **18-35%** Arises during admission: **29-64%** Post-op: 11-51% ICU: **81%** Nursing homes: 20-22% End of life: 88%
Neurocognitive Disorders: Alzheimer's Frontotemporal Lewy Body Parkinson's	Paranoia, behavioral changes, decreased affect, social isolation, mood lability/ irritability, functional impairment	Presents later in life, progressive, no previous hx Consider "pseudodementia": cognitive changes/functional impairment more common with depression in elderly patients	at age 65: 1-2% at age 85: **30%**

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Other Differential Diagnoses

Somatic symptom and Related Disorders

Illness Anxiety Disorder

- Preoccupation with presumed illness

Functional Neurological Symptom Disorder

Factitious Disorder (imposed on self or others)

Somatic Symptom Disorder

Evaluate:

Recent stressors/triggers

Isolated symptomatology vs global dysfunction

Good vs absent insight into beliefs

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Other Differential Diagnoses

Disruptive, Impulse-Control, and Conduct Disorders

Kleptomania

Evaluate: Delusions or hallucinations influencing stealing behavior

Other

Malingering (not a DSM diagnosis)

Evaluate: Evidence of secondary gain

Takeaways

- Include DSM-5-TR diagnostic criteria when evaluating for and diagnosing psychotic disorders
- Understand that multiple psychiatric diagnoses may present with “psychotic” symptoms at times
- **Not all hallucinations or delusions are schizophrenia or other psychosis**
- Continue to utilize this information in clinical practice and when consulting with colleagues and other specialties

- Questions and Discussion

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