Psychiatry 5th year

Chapter 3: Psychotic Disorders

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Psychosis

- Psychosis is a general term used to describe a distorted perception of reality. Poor reality testing may be accompanied by delusions, perceptual disturbances (illusions or hallucinations), and/or disorganized thinking/behavior.
- Can occur in patients with psychiatric illnesses or another medical conditions or secondary to substance and medication use.

WARDS TIP

Psychosis is exemplified by delusions, hallucinations, or severe disorganization of thought/behavior.

It was mentioned in the book twice (1st early & 2nd late in chapter) So i put it together here.

Delusions

Fixed, false beliefs that persist despite evidence to the contrary and that do not make sense within the context of an individual's cultural background or religion.

They can be categorized as either bizarre or nonbizarre. A *nonbizarre* delusion is a false belief that is plausible but is not true. Example: "The neighbors are spying on me by reading my e-mail." A *bizarre* delusion is a false belief that is impossible. Example: "Aliens are spying on me through a Wi-Fi connection in my brain."

Delusion Themes

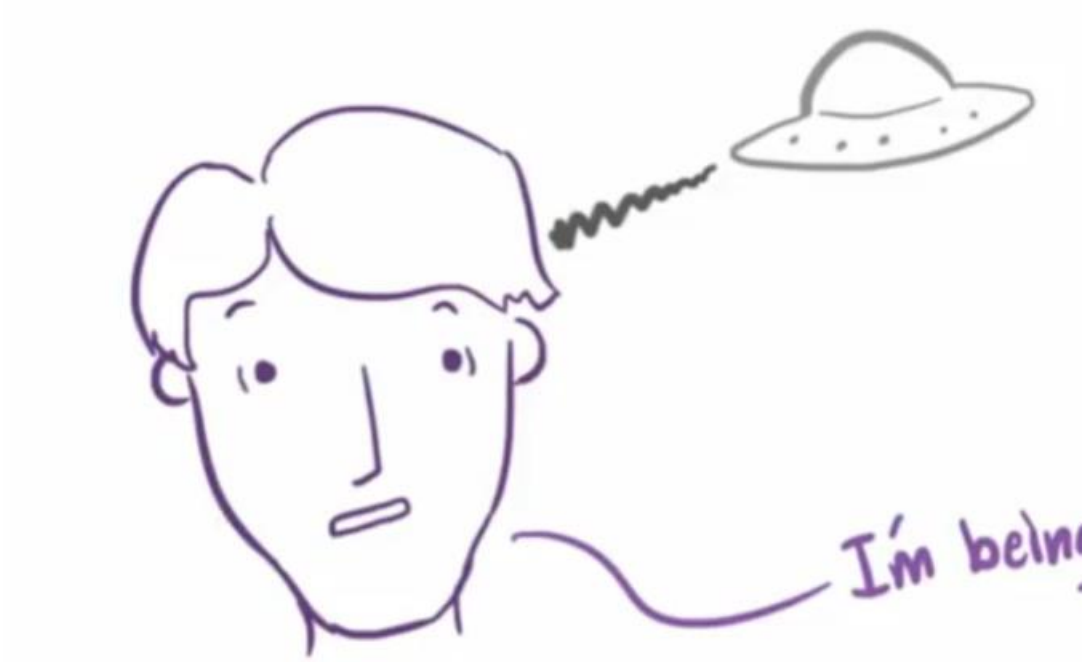
- ***Paranoid - Persecution delusions***: " someone is after me" , "The Central Intelligence Agency (CIA) is monitoring me and tapped my cell phone."
- ***Ideas of reference***: "The TV characters are speaking directly to me".
- ***Delusions of Control***: Includes **thought broadcasting** (belief that one's thoughts can be heard by others) and **thought insertion** (belief that outside thoughts are being placed in one's head).
- ***Grandiose delusions***: "I am a millionaire!" , "I am the all-powerful son of God".
- ***Delusions of Guilt***: "I am responsible for all the world's wars"
- ***Somatic delusions***: " I feel worms on my chest" , "A patient believing she is pregnant despite negative pregnancy tests and ultrasounds".
- ***Erotomanic delusions***: " Brad Pitt is in love with me".
- ***Mixed delusions***: two or more delusions occurring simultaneously; no delusion is predominant over the other
- ***Unspecified delusions***: a delusion that does not fit the criteria of other types or that cannot be clearly defined

Belief that cues in the external enviroment are uniquely related to this Individual.

Belief that one has special Powers Beyond normal Person.

Beleif that one has certain illness or health condition


WATCH OUT
FOR RAIN TONIGHT
They're sending
ME a message


I'm being

Delusional disorder occurs more often in middle-aged or older patients (after age 40). Immigrants, the hearing impaired, and those with a family history of schizophrenia are at increased risk.

Diagnosis and DSM-5 Criteria

To be diagnosed with delusional disorder, the following criteria must be met:

- One or more delusions for at least 1 month.
- Does not meet criteria for schizophrenia.
- Functioning in life not significantly impaired, and behavior not obviously bizarre.
- While delusions may be present in both delusional disorder and schizophrenia, there are important differences (see Table 3-1).

Prognosis

Better than schizophrenia with treatment:

- >50%: Full recovery.
- >20%: Decrease in symptoms.
- <20%: No change.

Treatment

Difficult to treat, especially given the lack of insight and impairment. Antipsychotic medications are recommended despite somewhat limited evidence. Supportive therapy is often helpful.

Important !!!

TABLE 3-1. Schizophrenia versus Delusional Disorder

Schizophrenia	Delusional Disorder

■ Bizarre or nonbizarre delusions
■ Daily functioning significantly impaired
■ Must have two or more of the following:
  ■ Delusions
  ■ Hallucinations
  ■ Disorganized speech
  ■ Disorganized behavior
  ■ Negative symptoms
	■ Usually nonbizarre delusions
	■ Daily functioning not significantly impaired
	■ Does not meet the criteria for schizophrenia, as described in the left column

Perceptual Disturbances

- **Illusion**: Misinterpretation of an ***existing*** sensory stimulus (such as mistaking a shadow for a black cat). → or evil spirit
- **Hallucination**: Sensory perception ***without*** an actual external stimulus.

Types of Hallucinations

Auditory – most commonly due to psychiatric illnesses (Schizophrenia) than neurological disease.

Visual: classically in neurological diseases (dementia), Delirium, or drug intoxication. Occurs in Schezophrenia and others abut less common.

Tactile: secondary to drug use (cocaine crawlies) or alcohol withdrawal.

Olfactory: an aura associated with temporal lobe epilepsy (burning rubber).

WARDS TIP

Auditory hallucinations that directly tell the patient to perform certain acts are called *command hallucinations*.

DIFFERENTIAL DIAGNOSIS OF PSYCHOSIS

- Psychotic disorder due to another medical condition. (1)
- Substance/Medication-induced psychotic disorder. (2)
- Delirium/Major neurocognitive disorder (dementia).
- Bipolar disorder, manic/mixed episode.
- Major depressive disorder with psychotic features.
- Brief psychotic disorder. (3)
- Schizophrenia. (4)
- Schizophreniform disorder. (5)
- Schizoaffective disorder. (6)
- Delusional disorder.

WARDS TIP

It's important to be able to distinguish between a delusion, illusion, and hallucination. A delusion is a fixed, false belief, an illusion is a misinterpretation of an external stimulus, and a hallucination is perception in the absence of an external stimulus.

WARDS QUESTION

Q: What is the most likely etiology in an elderly, medically ill patient presenting with the new onset of psychotic symptoms?
A: Delirium.

Psychotic Disorders Due to Another Medical Condition

- ***Central nervous system (CNS) disease*** (cerebrovascular disease, multiple sclerosis, neoplasm, Alzheimer disease, Parkinson disease, Huntington disease, tertiary syphilis, epilepsy [often temporal lobe], encephalitis, prion disease, neurosarcoidosis, AIDS).
- ***Endocrinopathies*** (Addison/Cushing disease, hyper/hypothyroidism, hyper/hypocalcemia, hypopituitarism).
- ***Nutritional/Vitamin deficiency states*** (B12, folate, niacin).
- ***Other*** (connective tissue disease [systemic lupus erythematosus, temporal arteritis], porphyria).

DSM-5 criteria for Psychotic Disorders Due to Another Medical Condition

- Prominent hallucinations or delusions.
- Symptoms do not occur only during an episode of delirium.
- Evidence from history, physical, or lab data to support another medical cause (i.e., not a primary psychiatric disorder).

② Substance/Medication-Induced Psychotic Disorder

Prescription medications that may cause psychosis in some patients include **digitalis**, **anesthetics**, **anticholinergics**, **nonsteroidal anti-inflammatory drugs (NSAIDs).** AntiMicrobials, AntiParKinson, AntiConvulsants, AntiHistamines Antihypertensive, MythelPhenidate, chemotherapeutic Agents.

Substances such as **alcohol**, **cocaine**, **hallucinogens** (LSD, ecstasy), **cannabis**, **benzodiazepines**, **barbiturates**, **inhalants**, and **phencyclidine** (PCP) can cause psychosis, either during intoxication or withdrawal.

Substance/Medication-Induced Psychotic Disorder

***DSM-5* Criteria**

- Hallucinations and/or delusions.
- Symptoms do not occur only during episode of delirium.
- Evidence from history, physical, or lab data to support a medication or substance-induced cause.
- Disturbance is not better accounted for by a psychotic disorder that is not substance/medication-induced.

(3) Schizophrenia

- a chronic psychiatric disorder characterized by a constellation of abnormalities in thinking, emotion, and behavior

There is no single symptom that is pathognomonic, and there is a heterogeneous clinical presentation.

Schizophrenia is typically chronic, with significant psychosocial and medical consequences to the patient.

What is Schizophrenia ?!

- It's not multi-personality disorder !

TABLE 3-1. Schizophrenia versus Delusional Disorder

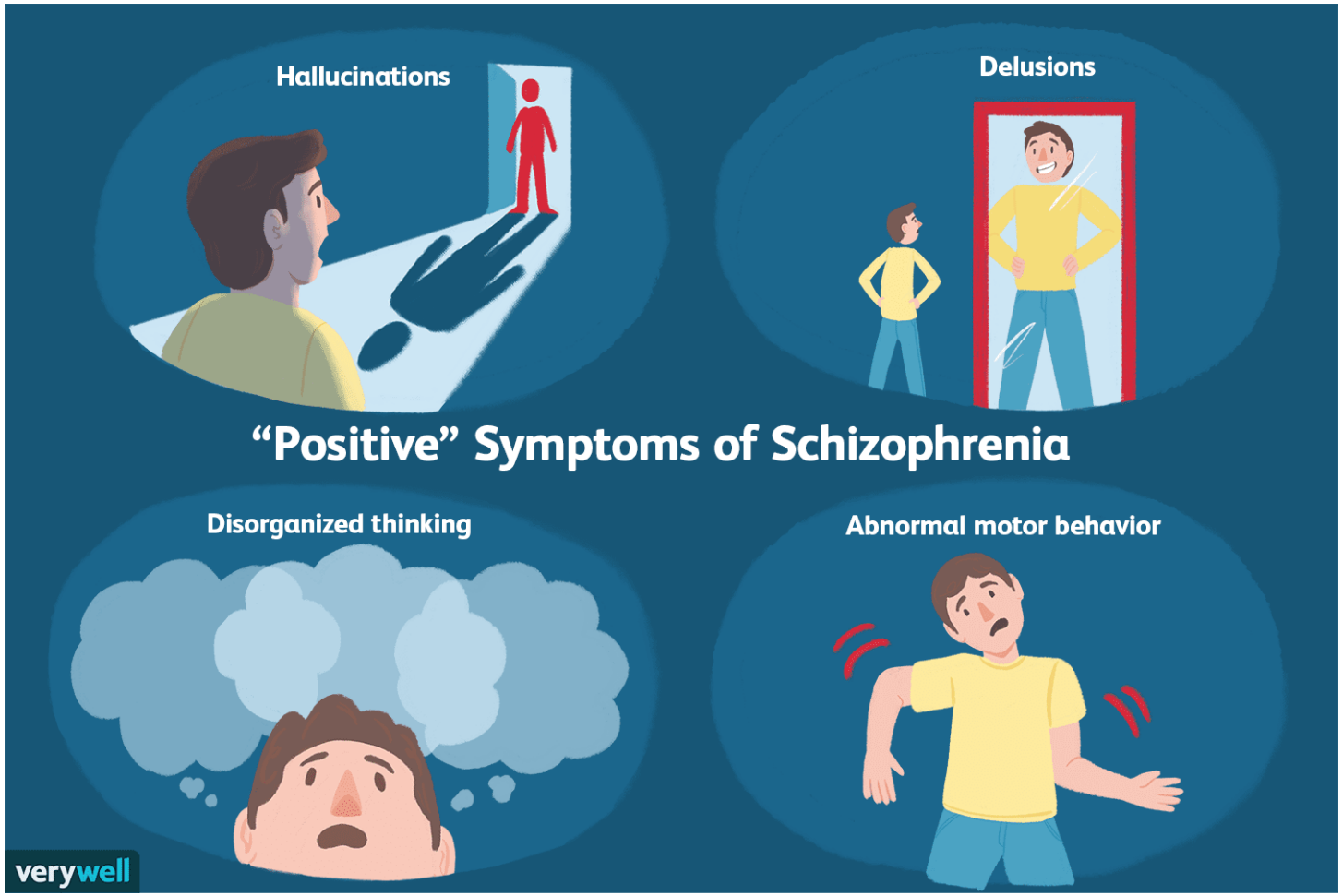
DSM-5 Criteria

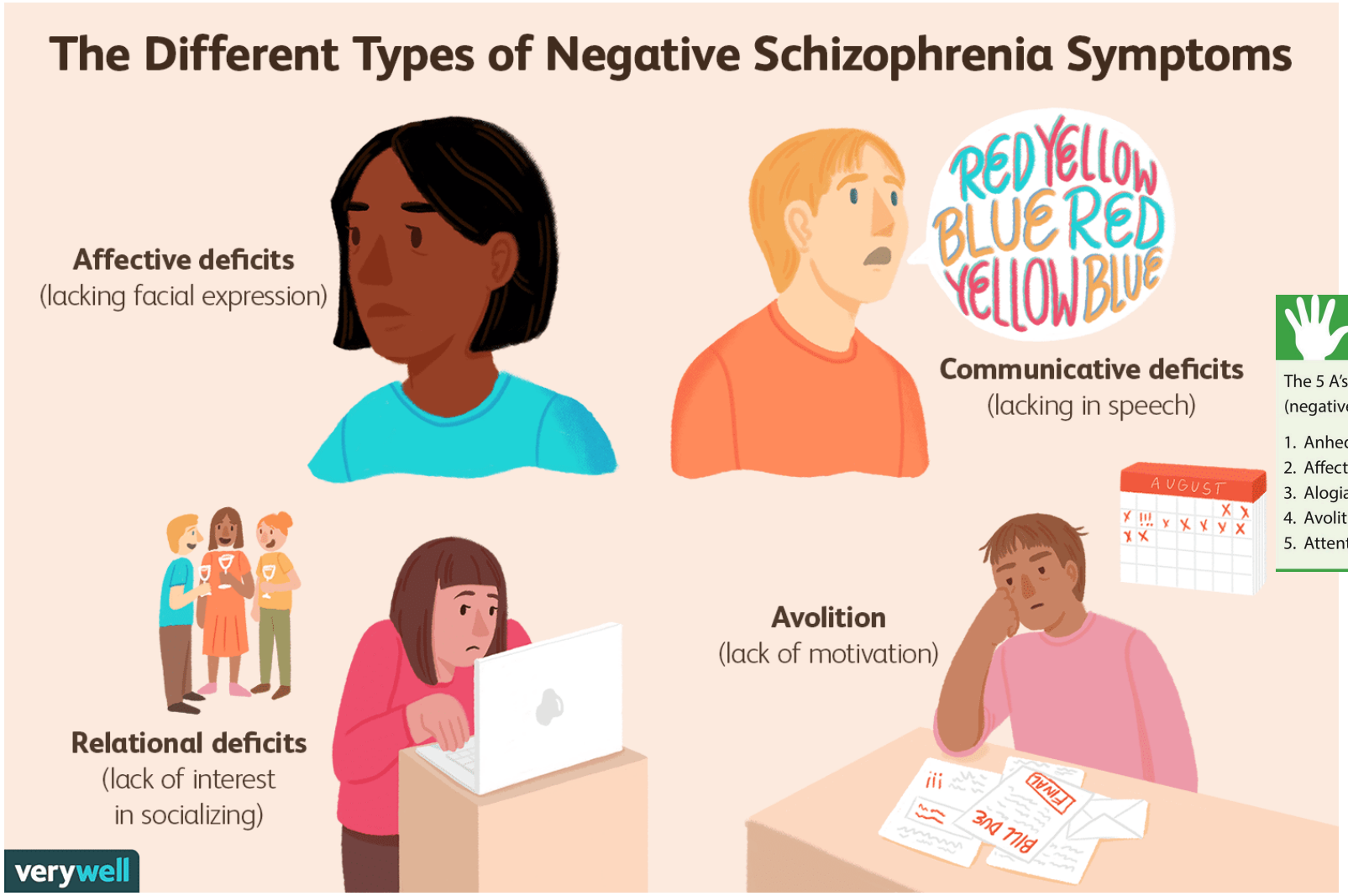
Schizophrenia	Delusional Disorder
■ Bizarre or nonbizarre delusions	■ Usually nonbizarre delusions
■ Daily functioning significantly impaired	■ Daily functioning not significantly impaired
■ Must have two or more of the following:	■ Does not meet the criteria for schizophrenia, as described in the left column
■ Delusions	
■ Hallucinations	
■ Disorganized speech	
■ Disorganized behavior	
■ Negative symptoms	

Positive Symptoms of Schizophrenia

- Excessive or distorted functioning , including Hallucinations, delusions, bizarre behavior, disorganized speech.
- These tend to respond more robustly to antipsychotic medications.

KEY FACT: Think of positive symptoms as things that are ADDED onto normal behavior





WARDS TIP

The 5 A's of schizophrenia (negative symptoms):

1. Anhedonia
2. Affect (flat)
3. Alogia (poverty of speech)
4. Avolition (apathy)
5. Attention (poor)

KEY FACT: Think of negative symptoms as things that are SUB-TRACTED or missing from normal behavior.

Negative Symptoms of Schizophrenia

- Flat or blunted affect, anhedonia (can't feel pleasure), apathy, alogia (lack of speech), and lack of interest in socialization.

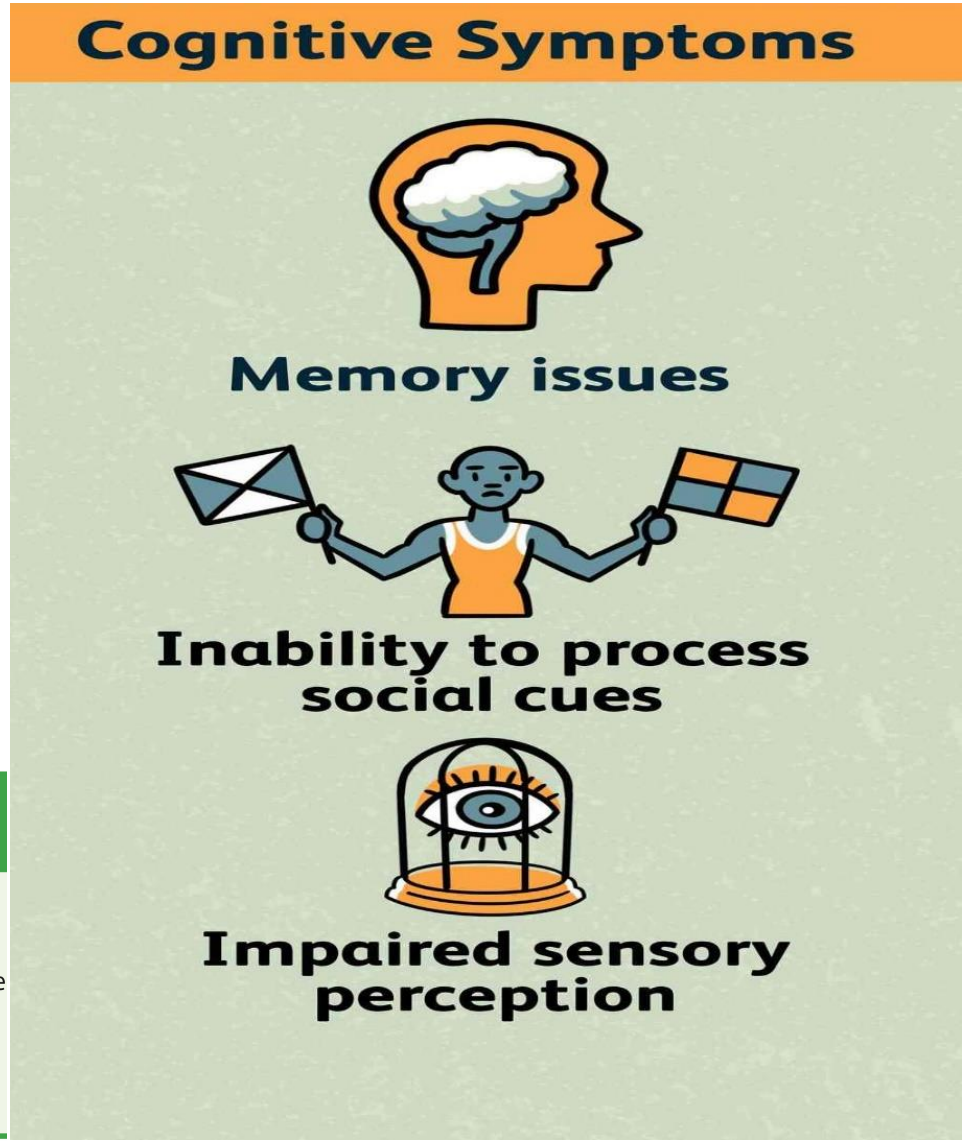
These symptoms are comparatively more often treatment resistant and contribute significantly to the social isolation and impaired function of schizophrenic patients.

Cognitive Symptoms of Schizophrenia

- Impairments in attention, executive function (planning), and working memory
- **These symptoms may lead to poor work and school performance.**

WARDS TIP

Stereotyped movement, bizarre posturing, and muscle rigidity are examples of catatonia, a syndrome which can be seen in schizophrenia, depression, bipolar disorder, and other psychiatric conditions.



Phases of Schizophrenia

The patient may become socially withdrawn and irritable. They may have physical complaints, declining school/work performance, and/or newfound interest in religion or the occult.

Prodromal: Decline in functioning that precedes the first psychotic episode.

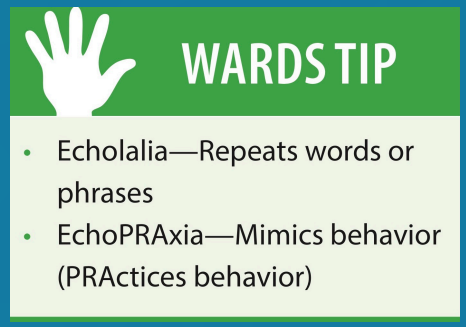
Psychotic: Perceptual disturbances, delusions, and disordered thought process/content.

Residual:
- Occurs following an episode of active psychosis.
- It is marked by mild hallucinations or delusions, social withdrawal, and negative symptoms.

Diagnosis of Schizophrenia

- DSM-5 criteria:
  - Diagnosis requires ≥ 2 of the following active symptoms, including ≥ 1 from symptoms #1–3:
    - 1. Delusions
    - 2. Hallucinations, often auditory
    - 3. Disorganized speech
    - 4. Disorganized or catatonic behavior
    - 5. Negative symptoms
  - **Symptom onset ≥ 6 months prior to diagnosis; requires ≥ 1 month of active symptoms over the past 6 months**.

- **Must cause significant social, occupational, or functional (self-care) deterioration.**
- **Duration of illness for at least 6 months (including prodromal or residual periods in which the above full criteria may not be met).**
- **Symptoms not due to effects of a substance or another medical condition.**



Psychiatric Exam Of Patients With Schizophrenia

- The *typical* findings in schizophrenic patients include:
  - Disheveled appearance.
  - Flat affect.
  - Disorganized thought process.
  - Intact procedural memory and orientation.
  - Auditory hallucinations.
  - Paranoid delusions.
  - Ideas of reference.
  - Lack of insight into their disease.

Keep in mind that schizophrenia can have a very heterogeneous presentation— patients may have schizophrenia without a disheveled appearance or clear negative symptoms.

Epidemiology of Schizophrenia

- Schizophrenia affects approximately 0.3–0.7% of people over their lifetime.
- Men and women are equally affected but have different presentations and outcomes: Men tend to present earlier than women + Men tend to have more negative symptoms and poorer outcome compared to women.
- Schizophrenia rarely presents before age 15 or after age 55.
- There is a strong genetic predisposition
  - 50% concordance rate among monozygotic twins.
  - 40% risk of inheritance if both parents have schizophrenia.
  - 12% risk if one first-degree relative is affected.
- Substance use is comorbid in many patients with schizophrenia. The most commonly abused substance is nicotine (>50%), followed by alcohol, cannabis, and cocaine.

■ Post-psychotic depression is the phenomenon of schizophrenic patients developing a major depressive episode after resolution of their psychotic symptoms.

Downward Drift

- Lower socioeconomic groups have higher rates of schizophrenia. This may be due to the **downward drift hypothesis**, which postulates that people suffering from schizophrenia are unable to function well in society and hence end up in lower socioeconomic groups. Many homeless people in urban areas suffer from schizophrenia.

KEY FACT

- Schizophrenia is more prevalent in lower socioeconomic groups likely due to "downward drift" (many patients face barriers to higher education, regular employment, and other resources, so they tend to drift downward socioeconomically).

PATHOPHYSIOLOGY OF SCHIZOPHRENIA: THE DOPAMINE HYPOTHESIS

Though the exact cause of schizophrenia is not known, it appears to be partly related to increased dopamine activity in certain neuronal tracts. Evidence to support this hypothesis is that most antipsychotics successful in treating schizophrenia are dopamine receptor antagonists. In addition, cocaine and amphet- amines increase dopamine activity and can cause schizophrenia-like symptoms.

Theorized Dopamine Pathways Affected in Schizophrenia

- *Prefrontal cortical:* Inadequate dopaminergic activity; responsible for negative symptoms.
- *Mesolimbic:* Excessive dopaminergic activity; responsible for positive symptoms.

Other Important Dopamine Pathways Affected by Antipsychotics

- *Tuberoinfundibular:* Blocked by antipsychotics, causing hyperprolactinemia, which may lead to gynecomastia, galactorrhea, sexual dysfunction, and menstrual irregularities.
- *Nigrostriatal:* Blocked by antipsychotics, causing Parkinsonism/ extrapyramidal side effects such as tremor, rigidity, slurred speech, akathisia, dystonia, and other abnormal movements.

KEY FACT

Akathisia is an unpleasant, subjective sense of restlessness and need to move, often manifested by the inability to sit still. Severe akathisia can be a risk factor for suicide.

WARDS QUESTION

Q: What are the most appropriate treatments for akathisia?
A: Tapering down antipsychotic medication, beta-blockers such as propranolol, or benzodiazepines.

Other Neurotransmitter Abnormalities Implicated In Schizophrenia

Elevated serotonin: Some of the second-generation (atypical) antipsychotics

(e.g., risperidone and clozapine) antagonize serotonin and weakly antagonize dopamine.

Elevated norepinephrine: Long-term use of antipsychotics has been shown to decrease activity of noradrenergic neurons.

Low gamma-aminobutyric acid (GABA): There is lower expression of the enzyme necessary to create GABA in the hippocampus of schizophrenic patients.

Low levels of glutamate receptors: Schizophrenic patients have fewer NMDA receptors; this corresponds to the psychotic symptoms observed with NMDA antagonists like ketamine.

Prognosis of Schizophrenia

Even with medication, 40–60% of patients remain significantly impaired after their diagnosis, while only 20–30% function fairly well in society. About 20% of patients with schizophrenia attempt suicide and many more experience suicidal ideation.

Several factors are associated with a better or worse prognosis:

- **Associated with Better Prognosis**
  - Later onset.
  - Good social support.
  - Positive symptoms.
  - Mood symptoms.
  - Acute onset.
  - Female gender.
  - Few relapses.
  - Good premorbid functioning.
- **Associated with Worse Prognosis**
  - Early onset.
  - Poor social support.
  - Negative symptoms.
  - Family history.
  - Gradual onset.
  - Male gender.
  - Many relapses.

Prognosis of Schizophrenia

KEY FACT

Schizophrenia has a large genetic component. If one identical twin has schizophrenia, the risk of the other identical twin having schizophrenia is 50%. A biological child of a schizophrenic person has a higher chance of developing schizophrenia, even if adopted into a family without schizophrenia.

KEY FACT

The lifetime prevalence of schizophrenia is 0.3–0.7%.

KEY FACT

Schizophrenia often involves neologisms. A neologism is a newly coined word or expression that has meaning only to the person who uses it.

WARDS QUESTION

Q: What is the typical age of onset for schizophrenia?
A: For men, 15–25. For women, 15–30, with a second (smaller) peak incidence in the late 40s.

KEY FACT

Computed tomography (CT) and magnetic resonance imaging (MRI) scans of patients with schizophrenia may show enlargement of the ventricles, diffuse cortical atrophy, and reduced brain volume.

Treatment of Schizophrenia

More on Positive Symptoms, Side effects → extrapyramidal symptoms, Neuroleptic malignant syndrome, Tardive Dyskinesia

- **First-generation (or typical) antipsychotic medications** (e.g., *chlorpromazine*, *fluphenazine*, *haloperidol*, *perphenazine*)
  - Primarily dopamine (mostly D2) antagonists – increases cAMP-.
- **Second-generation (or atypical) antipsychotic medications** (e.g., *aripiprazole*, *asenapine*, *clozapine*, *iloperidone*, *lurasidone*, *olanzapine quetiapine*, *risperidone*, *ziprasidone*)
  - These antagonize serotonin receptors (5-HT2) as well as dopamine (D4>D2) receptors (aripiprazole is a partial D2 agonist).

Higher risk of Metabolic Syndrome !!!

- Medications should be taken for at least 4 weeks before efficacy is determined.
- Clozapine is reserved for patients who have failed multiple antipsychotic trials due to its risk of agranulocytosis.

Treatment of Schizophrenia

Behavioral therapy attempts to improve patients' ability to function in society. Patients are helped through a variety of methods to improve their social skills, become self-sufficient, and minimize disruptive behaviors. **Family therapy** and **group therapy** are also useful adjuncts.

WARDS TIP

First-generation antipsychotic medications are referred to as typical or conventional antipsychotics (often called neuroleptics). Second-generation antipsychotic medications are referred to as atypical antipsychotics.

Side Effects of Antipsychotics

(10)

1 Extrapyramidal symptoms:

Hours to days:

- Acute Dystonia (muscle spasm, stiffness, oculogyric crisis). Treatment: benztropine, diphenhydramine.

Days to months:

- Akathisia (restlessness). Treatment: β-blockers, benztropine (anticholinergic that blocks M1 receptor), benzodiazepines.
- Parkinsonism (bradykinesia). Treatment: benztropine, amantadine.

Months to years:

- Tardive dyskinesia (chorea, especially orofacial). Treatment: benzodiazepines,

Side Effects of Antipsychotics

2. **Antihistaminic** (Sedation), **Anti a1 adrenergic** (orthostatic hypotension), **Antimuscarinic** (Dry mouth, Constipation) → especially with low-potency antipsychotics (chlorpromazine, thioridazine). → Treatment for symptom
3. **Metabolic syndrome**: weight gain, hyperglycemia, dyslipidemia, Highest risk with clozapine and olanzapine.
   More details next Page
4. **Endocrine**: hyperprolactinemia (galactorrhea), oligomenorrhea, gynecomastia.
5. **Cardiac**: QT prolongation.
6. **Neurologic**: neuroleptic malignant syndrome (medical emergency, myoglobinurea, fever, encephalopathy, elevated CK, muscle rigidity –Lead pipe-)
   More details next Page
7. **Ophthalmologic**: chlorpromazine—corneal deposits; thioridazine—retinal deposits.
8. **Clozapine**—agranulocytosis (monitor WBCs), seizures (dose related), myocarditis.
9. Dermatologic conditions → Rashes and photosensitivity

Side Effects of Antipsychotics

Metabolic syndrome (second-generation antipsychotics): A constellation of conditions— **elevated** blood pressure, **elevated** blood sugar levels, excess body fat around the waist, abnormal cholesterol levels—that occur together, **increasing** the risk for cardiovascular disease, stroke, and type 2 diabetes.

Treatment: Consider switching to a first-generation antipsychotic or a more "weight-neutral" second-generation antipsychotic such as aripiprazole or ziprasidone. Consider metformin if the patient is not already on it. Monitor lipids and blood glucose measurements. Refer the patient to primary care for appropriate treatment of hyperlipidemia, diabetes, etc. Encourage appropriate diet, exercise, and smoking cessation.

Tardive dyskinesia (more likely with first-generation antipsychotics): Choreoathetoid movements, usually seen in the face, tongue, and head.

Treatment: Discontinue or reduce the medication and consider substituting an atypical antipsychotic (if appropriate). VMAT-2 inhibitors such as valbenazine, benzodiazepines, Botox, and vitamin E may be used. The movements may persist despite withdrawal of the drug. Although less common, atypical antipsychotics can also cause tardive dyskinesia.

Neuroleptic malignant syndrome (NMS) (typically high-potency first-generation antipsychotics):

- Change in mental status, autonomic instability (high fever, labile blood pressure, tachycardia, tachypnea, diaphoresis), "lead pipe" rigidity, elevated creatine kinase (CK) levels, leukocytosis, and metabolic acidosis. Reflexes are decreased.
- NMS is a **medical emergency** that requires prompt withdrawal of all antipsychotic medications and immediate medical assessment and treatment.
- May be observed in any patient being treated with any antipsychotic (including second generation) medications at any time, but is more frequently associated with the initiation of treatment and at higher IV/IM dosing of high-potency neuroleptics.
- Patients with a history of prior neuroleptic malignant syndrome are at increased risk of recurrent episodes when retrialed with antipsychotic agents.

- A 24-year-old male graduate student without prior medical or psychiatric history is reported by his mother to have been very anxious over the past 9 months, with increasing concern that people are watching him. He now claims to “hear voices” telling him what must be done to “fix the country.

1- *Important workup?*

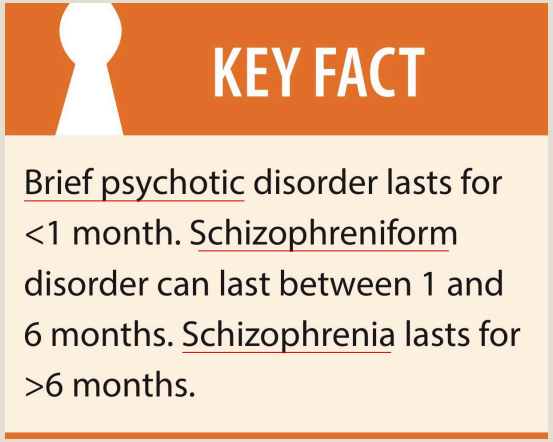
2- *Likely diagnosis?*

3- Next step?

1- Comprehensive metabolic panel, urine drug screen, Consider brain imaging

2- *If workup is unremarkable, schizophrenia*

3- Antipsychotics



- Mr. Torres is a 21-year-old man who is brought to the ER by his mother after he began talking about “aliens” who were trying to steal his soul. Mr. Torres reports that aliens leave messages for him by arranging sticks outside his home and sometimes send thoughts into his mind. On exam, he is guarded and often stops talking while in the middle of expressing a thought. Mr. Torres appears anxious and frequently scans the room for aliens, which he thinks may have followed him to the hospital. He denies any plan to harm himself but admits that the aliens sometimes want him to throw himself in front of a car, “as this will change the systems that belong under us.” The patient’s mother reports that he began expressing these ideas a few months ago, but they have become more severe in the last few weeks. She reports that during the past year, he has become isolated from his peers, frequently talks to himself, and has stopped going to community college. He has also spent most of his time reading science fiction books and creating devices that will prevent aliens from hurting him. She reports that she is concerned because the patient’s father, who left while the patient was a child, exhibited similar symptoms many years ago and has spent most of his life in psychiatric hospitals.

- 1- ***What differential Diagnoses should be considered?***
- ***2- What is Mr. Torres’s most likely diagnosis?***

1- schizoaffective disorder, medication/substance-induced psychotic disorder, psychotic disorder due to another medical condition, and mood disorder with psychotic features.

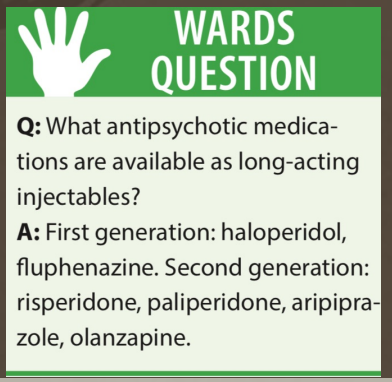
2- Schizophrenia

④ Schizophreniform Disorder

- Patients have similar symptoms to schizophrenia but **lasting < 6 months**. (Remember the Key Fact in slide 32)
- One-third of patients recover completely; two-thirds progress to schizoaffective disorder or schizophrenia.

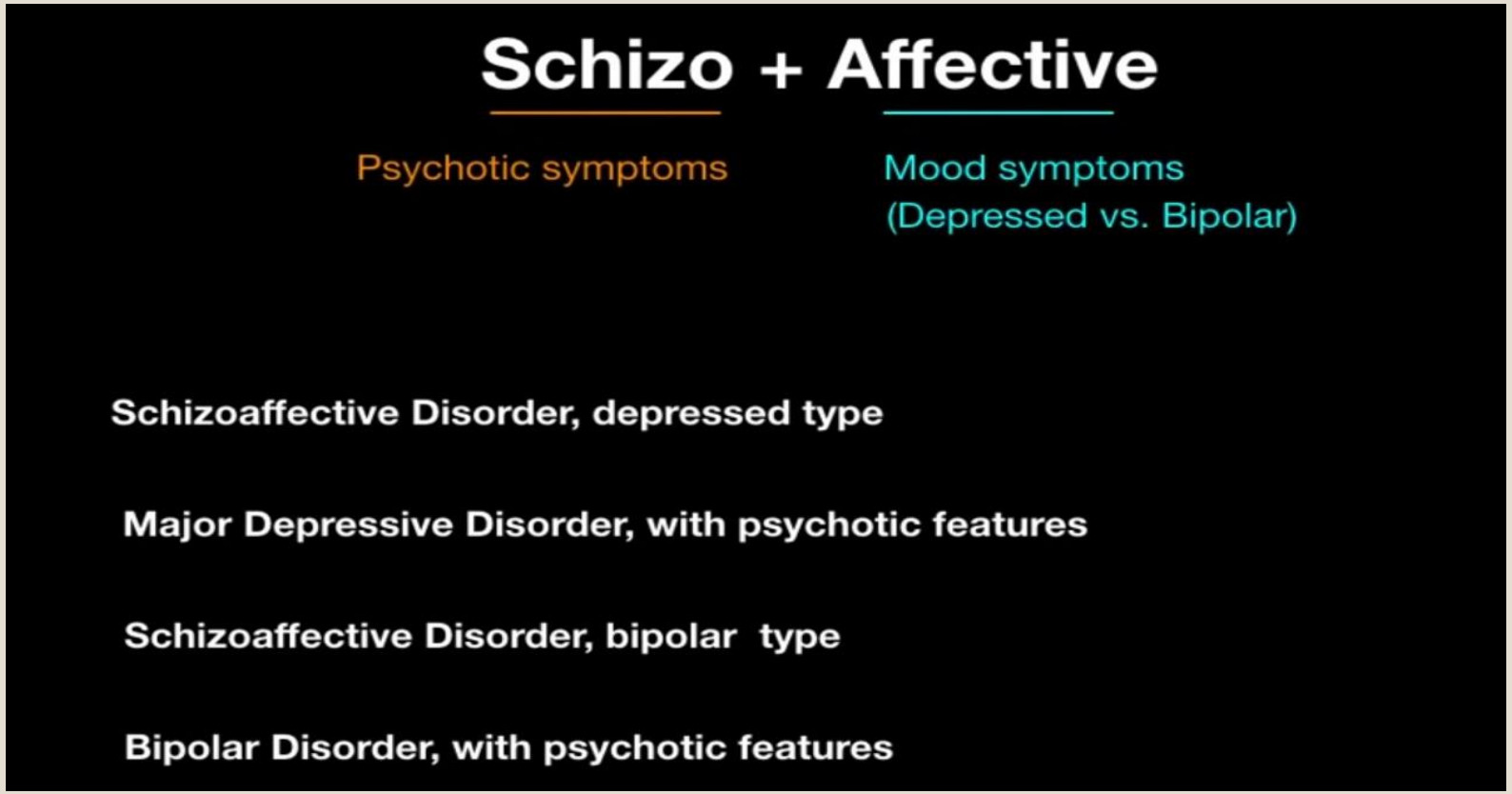
Treatment

Hospitalization (if necessary), 6-month course of antipsychotics, and supportive psychotherapy.



SchizophreniFORM = the FORMation of a schizophrenic, but not quite there (i.e., <6 months).

5 Schizoaffective Disorder

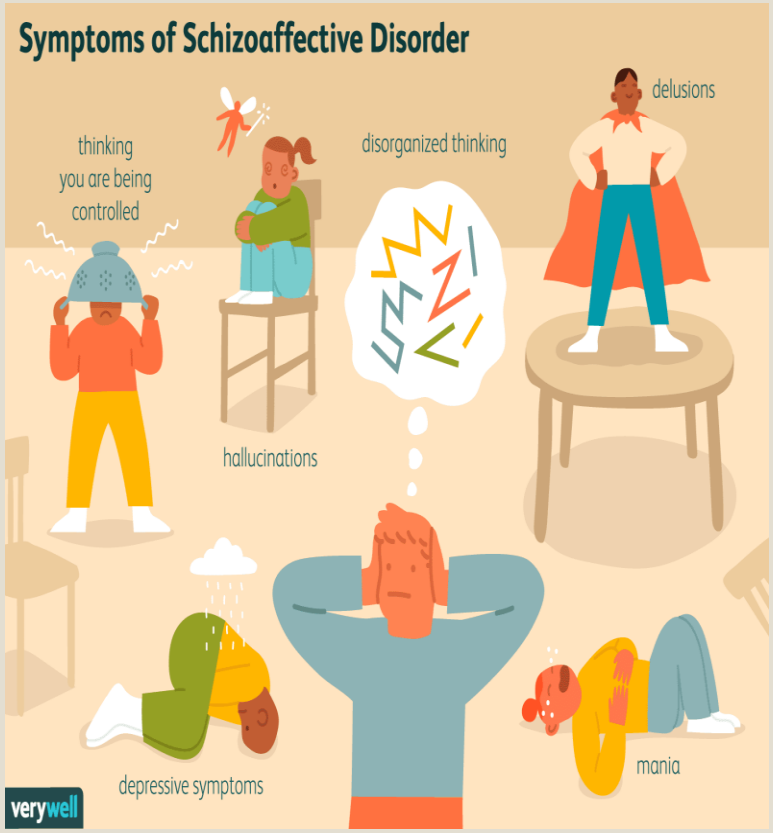


Schizoaffective Disorder

Diagnosis and DSM-5 Criteria

The diagnosis of schizoaffective disorder is made in patients who:

- Meet criteria for either a major depressive or manic episode during which psychotic symptoms consistent with schizophrenia are also met.
- Have delusions or hallucinations for 2 weeks in the absence of mood disorder symptoms (this criterion is necessary to differentiate schizoaffective disorder from a mood disorder with psychotic features).
- Have mood symptoms for a majority of the psychotic illness.
- Have symptoms not due to the effects of a substance (drug or medication) or another medical condition.



- Worse with poor premorbid adjustment, slow onset, early onset, predominance of psychotic symptoms, long course, and family history of schizophrenia

Treatment

- Hospitalization (if necessary) and supportive psychotherapy.
- Medical therapy: Antipsychotics (second-generation medications may target both psychotic and mood symptoms); mood stabilizers, antidepressants, or electroconvulsive therapy (ECT) may be indicated for treatment of mood symptoms.

Time Course

<1 month—brief psychotic disorder.
1–6 months—schizophreniform disorder.
>6 months—schizophrenia.

Prognosis from Best to Worst

Mood disorder with psychotic features > schizoaffective disorder > schizophreniform disorder > schizophrenia.

6 Brief Psychotic Disorder

- ≥ 1 positive symptom(s) **lasting between 1 day and 1 month**, usually stress-related.
- High rates of relapse, but almost all completely recover.

Culture-Specific Psychoses

The following are examples of psychotic disorders seen within certain cultures:

	Psychotic Manifestation	Culture
Koro	Intense anxiety that the penis will recede into the body, possibly leading to death.	Southeast Asia (e.g., Singapore)
Amok	Sudden unprovoked outbursts of violence, often followed by suicide.	Malaysia
Brain fag	Headache, fatigue, eye pain, cognitive difficulties, and other somatic disturbances in male students.	Africa

QUICK AND EASY DISTINGUISHING FEATURES

- **Schizophrenia:** Lifelong psychotic disorder.
- **Schizophreniform:** Schizophrenia for >1 and <6 months.
- **Schizoaffective:** Distinct mood episodes with psychosis persisting between mood episodes.
- **Schizotypal** (personality disorder): Paranoid, odd or magical beliefs, eccentric, lack of friends, social anxiety. Criteria for overt psychosis are not met.
- **Schizoid** (personality disorder): Solitary activities, lack of enjoyment from social interactions, no psychosis.

THANK YOU