Brief psychotic disorder

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INTRODUCTION

Brief psychotic disorder is a disorder defined by the presence of one or more psychotic symptoms that last for at least one day but less than one month with eventual full return to premorbid level of functioning [1]. The episode is typically associated with the experience of emotional turmoil or overwhelming confusion and may present with rapid shifts from one intense affect to another [1].

Brief psychotic disorder is often a provisional or retrospective diagnosis with a substantial rate of recurrence and subsequent diagnosis of another psychotic disorder or affective disorder with psychosis. Symptom duration is one factor distinguishing brief psychotic disorder from schizophreniform disorder (one to six months) and schizophrenia (at least six months). Differentiating brief psychotic disorder from other disorders that may present with similar symptoms is discussed below. (See 'Differential diagnosis' below.)

This topic discusses the epidemiology, pathogenesis, clinical features, assessment, diagnosis, and treatment of brief psychotic disorder. Topics related to other disorders presenting with psychosis are discussed separately.

- (See "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation".)
- (See "Psychosis in adults: Initial management".)
- (See "Schizophrenia in adults: Clinical features, assessment, and diagnosis".)
- (See "Bipolar disorder in adults: Clinical features", section on 'Psychosis'.)

- (See "Unipolar depression in adults: Clinical features", section on 'Psychotic'.)
- (See "Treatment of postpartum psychosis".)

TERMINOLOGY

Other terms for psychotic syndromes with brief onset and remitting course include bouffée delirantés (in French-speaking countries) and cycloid psychosis (in German-speaking countries) [1,2]. An overlapping diagnosis (acute and transient psychotic disorder) is included in the 11th edition of the International Classification of Diseases (ICD-11) [3]. The symptoms of ICD-11 acute and transient psychotic disorder are similar to those of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) brief psychotic disorder and include delusions, hallucinations, thought process disorganization, perplexity or confusion, and disturbances of affect and mood. (See 'Diagnosis' below.)

EPIDEMIOLOGY

Brief psychotic disorder is uncommon; community studies suggest the six-month to lifetime prevalence ranges from 0.05 to 2 percent. Little is known about the disorder's epidemiology due to a very low incidence and variations in the disorder's classification across countries. Available epidemiologic data are described below.

- The incidence of brief psychotic disorder was 1.8 per 100,000 person-years (95% CI 1.2-2.7) in the 15 years old or older population in two rural Irish communities [4]. Similarly, in a three-year follow-up study in the United Kingdom, the incidence of acute and transient psychotic disorder was 1.4 per 100,000 person-years [5].

- In the Suffolk County Study (United States), only 11 out of 547 (2.0 percent) of patients with first-admission psychosis met criteria for diagnosis of brief psychotic disorder at six months [6].

- The prevalence of brief psychotic disorder in first episode psychosis cohorts range from 2.1 (15 out of 722) in a 44-month Australian study [7] to 5.1 percent (10 cases out of 196) in a six-year follow-up study in two rural communities in Ireland [8].

Risk factors — There are little systematic data on risk factors for brief psychotic disorder [9]. There is more information regarding risk factors for other psychotic conditions with remitting course and acute onset.

- Brief psychotic disorder is more common in women compared with men [4,8]. Transient psychotic disorders, some of which would meet the criteria for brief psychotic disorder, have also been found to be more common in women than in men [5,10,11].

- A higher incidence of acute and transient psychotic disorders has been reported in resource-limited countries compared with resource-rich countries [11,12]. In the World Health Organization Determinants of Outcome Study based on 444 first onset nonaffective psychosis cases drawn from sites in eight countries, the incidence of nonaffective acute remitting psychoses were approximately 10 times higher in the two resource-limited country sites than the six resource-rich sites. The nonaffective acute remitting psychoses in that study were diagnosed based on the criteria introduced by the authors that required an acute onset (within one week) and complete remission of psychotic episode [11].

Comorbidity — Anecdotal evidence and diagnostic taxonomy have linked psychotic disorders with remitting course and acute onset with premorbid personality disorders. “Mini-psychotic” episodes as a potential feature of borderline personality disorder have been described. Research studies of the association between personality disorders and remitting psychoses with acute onset have produced mixed findings:

- In a sample of 51 patients with an acute, transient psychotic disorder in Denmark, 63 percent were diagnosed with a co-occurring personality disorder shortly after remission of psychotic symptoms [13]. The proportion of the sample diagnosed with a personality disorder decreased at one-year reassessment to 29 to 46 percent [14].

- A sample of 42 inpatients diagnosed with acute and transient psychotic disorders was compared with a matched control group of 42 surgical inpatients with acute illnesses who were free from mental health problems on the NEO five-factor personality inventory [15]. No difference between the groups was seen on any of the five personality subscales [16].

PATHOGENESIS

The causes of brief psychotic disorder are not known. Limited research data and more extensive research on other psychotic disorders with remitting course and acute onset implicate:

- **Stressful life events** – Stressful life events in the period immediately preceding onset have been implicated in cases of brief psychotic disorder and in other descriptions of brief psychosis [13,17-20]. The actual prevalence of such events in the life histories of patients with brief psychotic disorder has not been systematically investigated. It is sometimes unclear in individual patients whether a stressor was a precipitant or consequence of the

illness, or if it was unrelated. Case series have also described tentative links between the social and economic stresses of the coronavirus disease 2019 (COVID-19) pandemic and brief psychotic disorder [21].

- **Immigration** – Higher incidences of psychotic disorders with remitting course and acute onset have been found among immigrants to several resource-rich countries [22-24]. This finding may be related to higher prevalence rates of the disorder observed in resource-limited countries (see 'Risk factors' above). Another hypothesized contributing factor is heightened stress associated with discrimination and social adversity that many immigrants experience. (See 'Epidemiology' above.)

- **Genetics** – There are little systematic data on possible contribution of genetic factors to the etiology of brief psychotic disorder. Most of the available data on the genetic risk factors are from studies of other psychotic disorders with remitting course and acute onset [25-27]. Implications of these findings for brief psychotic disorder remain unclear.

- **Postpartum period** – Many cases of psychosis in the postpartum period meet diagnostic criteria for brief psychotic disorder [28]. (See "Postpartum psychosis: Epidemiology, clinical features, and diagnosis", section on 'Pathogenesis' and "Treatment of postpartum psychosis".)

CLINICAL MANIFESTATIONS

Brief psychotic disorder is characterized by symptoms of psychosis lasting, by definition, between one day and one month.

Symptoms of psychosis seen in the disorder include one or more of the following:

- Hallucinations – The perception of a sensory process in the absence of an external source. Hallucinations can be auditory, visual, somatic, olfactory, or gustatory.

- Delusions – A fixed, false belief. Delusions can have a persecutory, jealous, grandiose, or other content.

- Disorganized speech – Disorganized speech patterns reflect disruption in the organization of person's thoughts. Commonly observed forms of disorganized speech include tangentiality and circumstantiality.

- Disorganized behavior – A patient with grossly disorganized behavior is often recognized by their inability to complete daily, normative tasks (eg, dressing and cleaning oneself,

belongings in order). In some cases, disorganized behavior may manifest as catatonic behavior (eg, reduced or excessive motor activity, mutism, stereotyped movements).

COURSE

Symptoms of brief psychotic disorder, by definition, remit within a month [1].

There are little systematic data on the age of onset of brief psychotic disorder though small studies suggest it may be somewhat higher than the onset of schizophrenia (eg, late teens and early 20s) [11,25,29,30]. As an example, in one study of patients with first-episode psychosis, the mean ages at presentation for brief psychotic disorder and schizophrenia were 34.7 and 30.4 years, respectively [4].

Assessment of duration of the natural history of brief psychotic disorder is often complicated by early treatment which can lead to remission of psychotic symptoms.

Many individuals who initially met criteria for a brief psychotic disorder have gone on to meet criteria for other psychotic disorders or affective disorders with psychosis [9]. In the Suffolk County study of first-admission psychosis, only 3 of the 11 patients who met the diagnostic criteria for brief psychotic disorder at six months maintained the diagnosis at two-year follow-up [6]. Three patients received diagnoses of a mood disorder, two were diagnosed with schizophrenia or schizophreniform disorder, and three others with other disorders including psychotic disorder, not otherwise specified. In a study of first episode psychosis in Ireland, only 2 of 10 patients initially diagnosed with brief psychotic disorder maintained this diagnosis six years later [8].

A study based on registry data from Denmark identified evidence of excess mortality both from natural causes and suicide in patients initially recorded as having acute and transient psychotic disorder [31].

ASSESSMENT

A comprehensive clinical assessment of a patient presenting with new onset of psychosis includes a detailed past medical history and physical examination, psychiatric history, mental status examination, exclusion of general medical and substance-related causes of psychosis, assessment for co-occurring conditions, review of prior psychiatric and family history, and assessment of recent stressors and psychosocial functioning [32]. Additionally, we obtain collateral information from the patient's family and other supports.

In addition to the symptoms comprising diagnostic criteria for brief psychotic disorder assessment, we evaluate the patient for other features suggestive of brief psychotic disorder:

- Presence of marked stressors preceding symptom onset
- Lack of negative symptoms
- Confusion during the early course of illness

Diagnosis of brief psychotic disorder requires ongoing, longitudinal assessment of the patient's clinical status. Because the diagnostic criteria require remission within one month, the diagnosis is initially provisional and is often retrospective. Psychotic symptoms often recur subsequent to remission, in some cases leading to a final diagnosis of schizophrenia or other psychotic disorders.

We consider the individual's cultural and religious background in evaluating the clinical significance of the presenting symptoms. Some culturally sanctioned response patterns may mimic brief psychotic disorders. For example, individuals participating in some religious ceremonies may report hearing voices, but these are not perceived as abnormal by most members of the individual's community. Similarly, in some cultural contexts, bereaved relatives may report hearing, seeing, or interacting with the spirit of a recently deceased loved one. These experiences are not associated with pathological sequelae and are culturally sanctioned [1].

DIAGNOSIS

DSM-5-TR diagnostic criteria for brief psychotic disorder are as follows [1]:

- Presence of one or more of the following symptoms:
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Grossly disorganized or catatonic behavior
- Duration of an episode of the disturbance is at least a day but less than a month, with eventual full return to premorbid level of functioning.
- Absence of symptoms comprising a bipolar or depressive disorder, or psychosis resulting from substance use/withdrawal or a general medical condition.

Subtypes of the disorder include:

- With marked stressor – Symptoms are preceded by and apparently in response to a markedly stressful experience. This subtype was described as brief reactive psychosis in an earlier edition of the DSM.

- Without marked stressor.

- With postpartum onset – Within four weeks of delivery.

Differential diagnosis — Distinguishing brief psychotic disorder from other affective and nonaffective psychotic conditions is often difficult. An algorithm describes the diagnostic differentiation of psychoses (algorithm 1). The paragraphs that follow describe the principal features distinguishing these disorders.

Bipolar and depressive disorders — The main diagnostic challenge is to distinguish brief psychotic disorder from affective disorders, especially bipolar disorder with psychotic features. Patients with both affective disorders and brief psychotic disorder may present with psychosis, irritability, and disorganized behavior. However, individuals with brief psychotic disorder do not manifest the mood symptoms of mania or depression. In some cases, only continued observation of the patient's response to treatment and long-term course will clarify the diagnosis.

Nonaffective psychotic disorders — These include psychotic disorders that do not have associated affective disturbance. Longitudinal follow-up can be necessary to differentiate brief psychotic disorder from other nonaffective psychotic disorders, which typically last longer and are associated with greater long-term deficits in functioning.

Schizophreniform disorder — Schizophreniform disorder is distinguished from brief psychotic disorder by the following differences in diagnostic criteria:

- Psychotic symptoms are present for more than one month but less than six months.

- Two or more types of psychotic symptoms are present for a significant proportion of a one-month period if the patient is untreated.

- Negative symptoms may constitute one of the characteristic types of symptoms that are present.

Schizophrenia — Schizophrenia is distinguished from brief psychotic disorder by the following differences in diagnostic criteria (see "Schizophrenia in adults: Clinical features, assessment, and diagnosis", section on 'Clinical manifestations'):

- Psychotic symptoms are present for at least six months.
- Two or more types of psychotic symptoms must be present for a significant proportion of a one-month period if the patient is untreated.
- Negative symptoms may constitute one of the characteristic types of symptoms that are present.
- Functioning in one or more major areas (eg, interpersonal relationships, work, self-care) is markedly below the level achieved prior to onset.

Substance-induced psychoses — Intoxication with or withdrawal from a number of substances (including hallucinogens, cocaine, and amphetamines) are associated with acute onset of psychotic symptoms. Toxicological examination of patients presenting with psychotic symptoms of acute onset is necessary, especially in younger patients.

Psychosis due to general medical conditions — A number of neurologic (eg, seizure disorders), endocrine (eg, thyroid disease), and infectious diseases (eg, viral encephalitis) are associated with psychotic symptoms. A thorough physical examination is necessary, with laboratory testing or neuroimaging based on the findings.

TREATMENT

There are no evidence-based practice guidelines specifically for management of brief psychotic disorder. As such, our approach to individuals with brief psychotic disorder is typically the same as the general initial management of psychosis, regardless of cause. This includes antipsychotic medications and adjunctive supportive therapy. Management of psychosis is briefly discussed below; further discussion can be found elsewhere. (See "Psychosis in adults: Initial management", section on 'Initial management'.)

- **Ensuring safety/determining site of care** – The initial treatment decisions should be guided by the patient's ability to maintain safety. This should be assessed by direct questioning about homicidal or suicidal ideation (see "Suicidal ideation and behavior in adults"). Other considerations include assessing patient's ability to secure basic needs such as food and shelter. It is essential to consider collateral information obtained from family members, psychosocial supports, and other providers during the safety risk assessment and site of care determinations. (See "Psychosis in adults: Initial management", section on 'Safety risk and level of care'.)

- **Antipsychotic therapy** – For most patients with psychosis, we suggest a second-generation antipsychotic medication. Even though some patients with brief psychotic disorder recover with supportive care only, we are unable to identify these patients at the time the decision to treat with medications needs to be made. (See 'Course' above.)

  The choice of antipsychotic is based on presenting symptoms (eg, agitation or need for sedation), patient comorbidities, and side effect profile of the medication. As examples, risperidone starting at 1 mg twice daily and titrating to therapeutic range or aripiprazole starting at 10 mg per day and titrating to therapeutic range are often good choices due to their favorable side effect profiles. Dosing, pharmacology, and adverse effects of antipsychotic medications are found on the associated tables (table 1 and table 2). (See "Psychosis in adults: Initial management", section on 'Preference for second-generation agents'.)

  Some patients with severe anxiety and agitation also warrant adjunctive treatment with short-acting benzodiazepines. This is discussed elsewhere. (See "Assessment and emergency management of the acutely agitated or violent adult" and "Psychosis in adults: Initial management", section on 'Psychiatric symptoms'.)

  No medications have been approved by the US Food and Drug Administration specifically for treatment of brief psychotic disorder. Moreover, there are no clinical trials or case series examining the efficacy of treatments for brief psychotic disorder. Our recommendations for treatment are based on clinical experience and evidence of effective treatment for other psychotic disorders [32]. (See "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation" and "Schizophrenia in adults: Maintenance therapy and side effect management" and "Evaluation and management of treatment-resistant schizophrenia" and "Management of neuropsychiatric symptoms of dementia" and "Unipolar major depression with psychotic features: Acute treatment".)

  For patients who we suspect could have brief psychotic disorder (eg, psychosis improves within a month, no prior history of psychosis, and no premorbid characteristics that are concerning for chronic psychosis), we suggest continuing antipsychotic treatment for one to three months before discontinuing. As there are no widely accepted guidelines on the duration of treatment, this recommendation is based on our clinical experience. Medication should be tapered over two to four weeks, and during this time, the patient should be monitored weekly for signs of relapse.

  Longer treatment is needed if residual psychotic symptoms persist beyond one month or if the patient experiences a relapse of symptoms after stopping medication. For these

patients, further evaluation and reconsideration of the diagnosis of brief psychotic disorder is warranted. (See "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation".)

- **Supportive psychotherapy** – We recommend psychotherapy as an adjunct to antipsychotic therapy. No psychosocial interventions have been tested in brief psychotic disorder. Based on clinical experience, we suggest the use of supportive psychotherapy techniques such as reassurance and validation of realistic concerns. This may be particularly helpful in patients who are confused or frightened by the onset of psychotic symptoms. (See "Overview of psychotherapies", section on 'Supportive psychotherapy'.)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Psychotic disorders".)

SUMMARY AND RECOMMENDATIONS

- **Brief psychotic disorder** – Brief psychotic disorder is characterized by the presence of one or more psychotic symptoms lasting for up to one month with return to premorbid level of functioning. Brief psychotic disorder is often a provisional or retrospective diagnosis and must be differentiated from other disorders presenting with similar symptoms. (See 'Introduction' above and 'Differential diagnosis' above.)

- **Epidemiology** – Brief psychotic disorder is rare. Limited epidemiologic data suggest an incidence of 1.8 per 100,000 person-years. Approximately 2 to 5 percent of patients with first episode psychosis have brief psychotic disorder. (See 'Epidemiology' above.)

- **Clinical manifestations** – Psychotic symptoms may include hallucinations, delusions, disorganized speech or behavior. Symptoms are not better accounted for by mood disorder, other psychotic disorder, or effects of substance use. Symptoms may appear following a stressful life event. Negative symptoms are less likely to be present than in other psychotic disorders. (See 'Clinical manifestations' above.)

- **Assessment** – A comprehensive clinical assessment of a patient presenting with new onset of psychosis includes a detailed history and physical examination, and assessment for co-occurring conditions. We consider the patient's religious and cultural background in

making a diagnosis. We attempt to rule out culturally sanctioned experiences that may mimic psychotic experiences. (See 'Assessment' above and 'Diagnosis' above.)

- **Treatment** – Antipsychotic medications are an effective symptomatic treatment of psychosis, regardless of underlying cause, and are the standard initial treatment for most cases. Supportive psychotherapy that offers reassurance and validation of realistic concerns may be a helpful adjunct to medication. Specific recommendations regarding selection of medication and psychotherapy as well as other aspects of acute care for acute psychosis are provided separately. (See "Psychosis in adults: Initial management".)

  For patients who we suspect have brief psychotic disorder (eg, psychosis improves within a month, no prior history of psychosis, and no premorbid characteristics that are concerning for chronic psychosis), we suggest continuing treatment for at least one to three months and then slowly tapering the medication (**Grade 2C**). We monitor patients who are tapering off medications on a weekly basis throughout the taper period and every two to three weeks thereafter for several months.

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