Psychotic Behaviour

Definition / Supporting Information

Psychotic behavior is a mental health condition that causes an individual to perceive or interpret things differently from those around them. Hallucinations and delusions are two forms of psychotic symptoms.

Psychotic behaviours need to be differentiated from developmental features such as imaginary friends in young children.

Essential History

Ask about:

- Symptoms
  - Delusions
    - Belief or impression maintained despite being contradicted by reality or rational argument
  - Hallucinations
    - An experience involving the apparent perception of something not present
  - Disorganised speech
  - Grossly disorganised behavior
    - Stupor
    - Inactivity
    - Mania
    - Rigidity or extreme flexibility of the limbs
    - Unusual / odd behaviour
  - Associated features
  - Low mood / depression
  - Alcohol consumption
  - Illicit drugs / legal highs
  - Prescribed / over-the-counter medication history
  - So-called negative symptoms (indicative of psychotic illness / possible schizophrenia)
    - Avolition
      - Lack of interest or engagement in goal-directed behavior (eg, school or work)

        - Alogia
            - Poverty of speech
        - Affective flattening
            - Diminished range of emotional expression (eg, poor eye contact, reduced body language)
- Medical history
- Psychosocial situation
    - Social networks
    - Relationships
    - History of trauma
- Developmental situation and maturity
    - Social, cognitive and motor development
- Physical health and wellbeing
    - Weight
    - Height
    - Diet
    - Exercise
    - Sexual health
- Social situation
    - Accommodation
    - Culture and ethnicity
    - Recreation
    - Carer responsibilities
    - Social history
        - Carer history
        - Previous social services involvement
- Educational and occupational situation
    - Attendance at school or college
    - Educational attainment
    - Employment
    - Functional activity
- Economic status

‘Red Flag’ Symptoms and Signs

Ask about:

- Symptoms of confusion and disorientation
- Associated fever
- Headache
- Other neurological symptoms

- Multiple psychotic symptoms
- Suicidal thoughts and intent to self-harm
- Self-neglect
  - Poor school attendance
- Onset of symptoms (sudden or gradual)
- Level of distress
- Impact on overall functioning

Look for:

- Neurocognitive deficits
- Symptoms of raised intracranial pressure
- Neurological signs
- Evidence of physical neglect

Differential Diagnosis / Conditions

- Medical disorders
  - Hypo- or Hyperthyroidism
  - Anti-NMDA receptor encephalitis
  - Meningitis
  - Encephalitis
  - Substance and alcohol misuse
  - Medications
  - Migraines
  - Electrolyte imbalance
  - Seizure disorders
  - Occipital lobe tumours
- Schizophrenia
  - Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5)DSM V defines it as a severe and chronic mental disorder characterised by disturbances in thought, perception and behaviour
  - Psychotic symptoms behaviour canare likely to be the first presenting sign of schizophrenia
  - Other ‘positive symptoms’ (eg, hallucinations and delusions)
  - ‘Negative symptoms’
    - Emotional apathy
    - Lack of motivation
    - Poverty of speech
    - Social withdrawal
    - Self-neglect
- Psychiatric disorders with psychotic features
  - Major depressive disorder with psychotic features

  - Bipolar disorder with psychotic features
  - Anxiety disorders with psychotic features
  - Oppositional / conduct disorders with psychotic features
    - Oppositional defiant disorder (ODD)
    - Symptoms are invariably seen in the home
    - Frequently focused on one authority figure
    - Behaviours must be frequent, severe, and persistent
      - Present for > 6 months
    - Conduct disorder
    - Verbal and physical aggression
    - Deceitfulness
    - Theft
    - Serious rule violations
    - Property destruction
  - Neurodevelopmental disorders with psychotic features
    - Attention-deficit hyperactivity disorder (ADHD)
    - Autistic spectrum disorders (ASDs)
- Miscellaneous conditions
  - Night terrors
  - Bereavement
  - Psychosocial adversity
  - Severe physical and or sexual abuse
- Transitional objects and imaginary companions
  - Magical, animistic thinking is common and developmentally normal in preschool and early school-aged children
  - Imaginary companions and transitional objects imbued with lifelike qualities by the child are normal in early childhood
  - Normal phenomena should gradually disappear by the end of middle childhood
  - Transitional objects and imaginary companions occurring as part of normal development should be distinguished from those of the severely disturbed child
  - Unlike the benign imaginary companions of a normal child, the hallucinatory experiences of the dissociative or psychotic child can be:
    - Threatening
    - Frightening
    - Aggressive toward others
    - Not under the child’s controls

Investigations

To be undertaken by specialist practitioners (eg, General Paediatric / Community Paediatric / Neurology Team(s)) usually alongside child and adolescent psychiatric assessments:

- Blood tests
  - Electrolytes
  - Thyroid function
  - Fasting blood glucose
  - Glycated haemoglobin (HbA1c)
  - Blood lipid profile
  - Prolactin levels
- Toxicology screen
- Cerebrospinal fluid examination may be indicated in some cases
- Consider a magnetic resonance imaging (MRI) brain scan
  - If there are associated neurological symptoms or neurological origin of symptoms suspected
- Consider electroencephalogram (EEG), if seizures suspected
- Relevant assessments [NICE clinical guideline 155, section 1.3.4]
  - Risk
  - Psychiatric
  - Psychological and psychosocial
  - Developmental
  - Physical health and wellbeing
  - Social
  - Educational and occupational
- If antipsychotics to be started
  - Check pulse and blood pressure
  - Conduct electrocardiogram (ECG)
  - Measure weight, height, waist and hip circumference

Treatment Approach

To be undertaken by non-specialist practitioner (eg, General Practitioner (GP) Team(s)):

- Treat associated febrile or toxic illness
- Consider stopping medication known to have a side-effect of causing psychotic symptoms
- Review signs of substance misuse
- Supporting patients, parents / carers and siblings
- Monitoring specialist-initiated medical treatments

To be undertaken by specialist practitioners (eg, Child and Adolescent Psychiatrist / Neurology Team(s)):

- Specialist assessment and treatment of the underlying psychiatric condition
- Specialist assessment and management of any new psychiatric disorders as sequelae of the trauma (eg, anxiety, adjustment disorder)
- Pharmacological interventions
  - Treatment of underlying organic disorder (via General Paediatrician / Paediatric Neurology Team(s))
  - Emergency treatment of alcohol or substance misuse
    - Through the General Paediatrician Team(s)
  - Treatment of pre-morbid ADHD (via Community Paediatrician / Child and Adolescent Psychiatrists)
  - Antidepressants
  - Antipsychotics
- Non-pharmacological interventions (via Child and Adolescent Mental Health Services (CAMHS) Team(s))
  - Talking therapies
  - Behavioural and cognitive interventions
  - Family therapy
- Supporting patients, parents / carers and siblings

When to Refer

Refer to a paediatric specialist if:

- Underlying medical disorder is suspected
- Safeguarding concerns

Escalate care to CAMHS or early intervention in psychosis service (EIS) if:

- First presentation of sustained, distressing psychotic symptoms
  - Which may include thought disorder and other multiple psychotic symptoms
- Suicidal ideation or intent
- Violence or serious recent history of violence
- Suspicion of serious substance abuse
- Assessment for initiation or continuation of treatment with psychotropic medication

‘Safety Netting’ Advice

- Sudden onset of psychosis with or without associated neurological signs, at risk behaviour
  - Suicidal ideation or intent
  - Self-harming behaviours should lead to seeking urgent medical advice
- Devise a care plan aimed at reducing risk to the patient and others

- Share the plan between the patient, families, professionals and others involved in the patient's care
- Refer to local child and adolescent psychiatrist

General considerations:

- Discuss confidentiality with patient and carers (eg, consent)
- Always assess capacity and competence
- Offer young people deemed "Gillick competent" consultation time also without their parents / carers
  - Chaperoning recommended
- Always consider vulnerability and safeguarding
- When seeing a child or young person who is on antipsychotic treatment in clinic, record their mental state and consider possible side-effects of treatment:
  - Weight gain
  - Checking blood pressure
  - Take a history of symptoms of diabetes
- Consider treatment non-adherence
- Always investigate first episode of early-onset psychosis to exclude treatable organic causes

Patient / Carer Information

**Please note: whilst these resources have been developed to a high standard they may not be specific to children.*

- Psychosis (Web page), the NHS website
- Schizophrenia (Web page), the NHS website
- Psychosis (Web page) Young Minds

Resources

National Clinical Guidance

Diagnosing, assessing and managing bipolar disorder in young people in secondary care (Web page), NICE guideline NG12, National Institute for Health and Care Excellence

Psychosis and schizophrenia in children and young people: recognition and management (Web page), NICE clinical guideline CG155, National Institute for Health and Care Excellence

Suggested Resources

**Please note: these resources include links to external websites. These resources may not have national accreditation and therefore PCO UK cannot guarantee the accuracy of the content.*

Psychosis 1: Recognition, Assessment and Epidemiology (Web page), MindEd

Barry H, Hardiman O, *et al.* Anti-NMDA receptor encephalitis: an important differential diagnosis in psychosis. *Br J Psychiatry* 2011;199:508–509 [PubMed]

Downs J, Lechler S, Dean H, *et al*. The association between comorbid autism spectrum disorders and antipsychotic treatment failure in early-onset psychosis: a historical cohort study using electronic health records. *J Clin Psychiatry* 2017;78(9):e1233–e1241 [PubMed]

Edelsohn GA. Hallucinations in children and adolescents: considerations in the emergency setting. *Am J Psychiatry* 2006;163:781–785 [PubMed]

Garralda ME. Hallucinations in children with conduct and emotional disorders: I. The clinical phenomena. *Psychol Med* 1984;14:589–596 [PubMed]

Seidman L, Shapiro D, Stone W, *et al*. Association of neurocognition with transition to psychosis: baseline functioning in the second phase of the north American prodrome longitudinal study. *JAMA Psychiatry* 2016;73(12):1239–1248 [PubMed]

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