VIGNETTES AND SPECIFIC RECOMMENDATIONS FOR DIFFERENTIAL DIAGNOSIS

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CHR and OCD

- Overlap:
  - Intrusive thoughts and preoccupations
  - Anxiety and distress
- Differences:
  - CHR: Thoughts may have delusional quality (e.g., suspicious or bizarre themes)
  - OCD: Ego-dystonic intrusive thoughts, repetitive behaviors to counter distress
- Key Question: *Are the thoughts aligned with the patient's sense of reality, or do they seem detached from reality?*

Lundin et al., 2024

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CHR and Autism

- Overlap:
  - Social withdrawal or awkwardness
  - Cognitive rigidity
- Differences:
  - CHR: Recent functional decline; delusional ideation or perceptual abnormalities
  - Autism: Lifelong social and communication challenges; restricted interests
- Key Question: *Is this a new onset of symptoms, or do they align with a long-standing developmental pattern?*

Lundin et al., 2024

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CHR and Depression

- Overlap:
  - Sadness or low mood
  - Reduced motivation or energy
  - Social withdrawal
- Differences:
  - CHR: Blunted or flat affect, unusual thought content, or perceptual changes unrelated to mood
  - Depression: Persistent sadness, guilt, or hopelessness tied to life events, along with somatic symptoms like changes in appetite or sleep
- Key Question: *Are these symptoms reflective of mood dysregulation, or are they indicative of broader cognitive or perceptual changes?*

Lundin et al., 2024

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CHR and Bipolar

- Overlap:
  - Grandiosity
  - Periods of high energy or agitation
  - Unusual or erratic behavior
- Differences:
  - CHR: Unusual thought content, perceptual changes
  - Bipolar: Clear mood episodes (mania or depression) with changes in activity, sleep, and self-esteem tied to these episodes
- Key Question: *Are the symptoms linked to distinct mood episodes, or do they suggest broader cognitive or perceptual disruptions?*

Lundin et al., 2024

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CHR and PTSD

- Overlap:
  - Hypervigilance
  - Difficulty distinguishing reality (e.g., flashbacks)
- Differences:
  - CHR: Unusual thought content, suspiciousness, or perceptual changes unrelated to trauma
  - PTSD: Symptoms tied to specific traumatic events; re-experiencing and avoidance behaviors
- Key Question: *Are the symptoms rooted in a traumatic experience, or are they broader in scope?*

Lundin et al., 2024

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CHR and Dissociation

- Overlap:
  - Experiences of disconnection from reality
  - Difficulty distinguishing internal vs. external stimuli
  - Voices or auditory phenomena
- Differences:
  - CHR: Voices tend to emerge later; not as often related to trauma; more associated with paranoia, unusual thought content, or cognitive-perceptual disturbances
  - Dissociation: Often autobiographical and trauma-related, childlike voices more common, voices generally exert less control, frequent amnesia or memory gaps
- Key Question: *Are these experiences primarily delusions or hallucinations typical in schizophrenia spectrum disorders without direct links to concepts like "identity fragmentation?"*

Lundin et al., 2024

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Substance-Induced and Primary Psychosis Disorders

- Overlap
  - Psychosis Symptoms
- Differences/Key Questions:
  - Temporal Relationship
  - Resolution of Symptoms
  - Severity and Duration
  - Substance Use History
  - Differentiation Through Abstinence
  - Type of symptom by type of drug
  - Other Associated Symptoms

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Substance-Induced and Schizophreniform

Feature	Substance/Medication-Induced Psychotic Disorder (SIPD)	Schizophreniform Disorder
Core Symptoms	Delusions and/or hallucinations	Delusions, hallucinations, disorganized speech, disorganized behavior, or negative symptoms
Timing	Symptoms occur during or soon after substance use, intoxication, or withdrawal	Symptoms arise independently of substance use
Duration	Symptoms resolve shortly after the substance clears the system	Lasts at least 1 month but less than 6 months
Causation	Directly linked to substance or medication use	Not due to substance use or medical conditions
Negative Symptoms	Less common	More common
Impairment	Clinically significant distress or impairment	May or may not cause functional impairment

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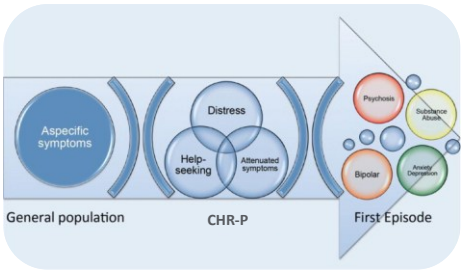
CHR and Psychosis



- Overlap:
  - All the symptoms
- Differences:
  - CHR: More insight, less severe, less functional impairment
  - PTSD: Less insight, more severe, more impairment
- Key Question: *Are the symptoms subthreshold, or have they crossed into psychosis based on insight, severity, and impact on functioning?*

Lundin et al., 2024

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Comorbidity

- Bipolar & CHR
  - In the context of mania vs. euthymic mood
- Anxiety & CHR
  - Clearly intertwined
  - Normalize
  - OCD Rumination: overthinking that's more voluntary
  - OCD Obsessions: intrusive, more distressing
  - Voices- Ask "Do you hear the voice like you hear mine?"
- Trauma & CHR
  - If symptoms only occur when thinking about the traumatic event, consider trauma diagnosis
  - Delusions or Trauma: collateral reports; regardless, be trauma-informed
  - Childhood sexual trauma linked to future conversion to psychosis
  - Bullying is common
- DID & CHR
  - Dissociation is usually autobiographical and trauma-related
  - Voices in CHR emerge later
  - Child voices more common in DID
  - Voices generally exert less control
  - Amnesia is more common in DID
- Substances
  - Consider type of drug
  - Cannabis
  - Stimulants
  - Psychodelics
  - Motivational approach

Ered et al., 2025

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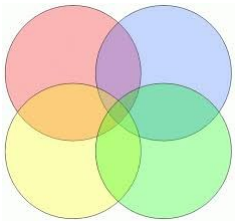
CHR and a Transdiagnostic Approach



- Focus on common processes across disorders
- Highlight shared vulnerabilities (e.g., cognitive biases, stress reactivity)
- Recognizes overlapping symptoms
- Emphasizes individual needs
- Key Question: *What underlying mechanisms (e.g., trauma, stress, neurodevelopmental factors) explain the symptom?*

Lundin et al., 2024

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Vignettes: Dissociation

John reported experiencing multiple "people" in his head, each with distinct voices and the ability to control his thoughts and behavior. He referred to the most prominent one as his "imaginary friend," present since he was 3-4 years old. This persona often takes over during stress, pursuing different goals but generally leading to positive outcomes, which he finds confusing and distressing. He described episodes where he feels like a figment of his own imagination while the "people" feel real. These episodes occur several times a week and can last for hours, especially when the "imaginary friend" is in control, diminishing his reality and identity. He attributes these experiences to childhood sexual abuse, suggesting that he has compartmentalized the trauma into this persona, which displays behaviors contrasting with his own. Despite the distress, he believes strongly in the reality of this "imaginary friend" during these episodes and feels uncertain about challenging this belief. He demonstrates insight by linking these experiences to his trauma, viewing them as part of his coping mechanism.

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Vignettes: CHR Not Dissociation

John described experiencing multiple “voices” in his head, each telling him different things and sometimes influencing his thoughts and behavior. One occasionally pushes him toward actions that feel inconsistent with his usual behavior. While they don’t happen that often (a few times per month and only briefly) and they didn’t start until he was a teenager, these episodes are confusing and distressing, particularly when he worries what will happen if he doesn’t do what the voices tells him to do. John also reported episodes where he feels unreal, while the voice feels more real than himself. These episodes have increased in frequency and duration over the past year without a precipitating incident. He explained that these experiences make him question his sense of self, particularly when the voice influences his behavior, adding to his distress. He isn’t completely convinced the voices are real, and he primarily views them as unusual and outside of his control.

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Vignettes: Autism

Jackie reports increased sensitivity to noise over the past 2-3 months, noting discomfort from low sounds (like a refrigerator humming) and loud noises. They bought noise reduction earplugs to help, experiencing sound sensitivity 4-6 times a week for a few hours. While bothersome, it doesn't affect their functioning when using earplugs. They attribute this sensitivity to neurodivergence, possibly ADHD or autism, and mention experiencing ringing and buzzing in their ears every couple of months.

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Vignettes: CHR Not Autism

Wanda reported daily, subtle changes in her physical appearance, which make it hard for her to recognize herself, especially in mirrors. She has not experienced difficulty recognizing others. This distressing experience began around 2020, coinciding with her depression. In 2021, she covered mirrors with newspaper for about a year to cope but now avoids mirrors without covering them worried that there might be a parallel universe hidden in them.

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Vignette (Folger et al. 2019)

Michael is a 13-year-old boy born in Vietnam to a mother with serious mental illness and adopted by his current family. In his first mental health evaluation when he was 10, Michael' psychiatric nurse practitioner diagnosed him with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD). Pragmatic language and syntax deficits were also noted from an early age.

Last year, while in 6th grade, Michael exhibited anxiety and perseverative beliefs. He began “talking to himself in his room” and using neologisms. A school-based evaluation resulted in educational diagnoses of ADHD and ASD based on social disconnectedness and invading others' personal space. Michael' parents felt “something else was going on” and sought a second opinion. Considering Michael's history, previous assessments, and their assessment battery (Behavior Assessment System for Children, Behavior Rating Inventory of Executive Function, Autism Diagnostic Observation Schedule, and Rorschach Inkblot Test), the team characterized his current symptoms as “Attenuated Psychosis Syndrome.”

A few months later, clinicians in the psychiatry department confirmed symptoms of functional decline, cognitive disorganization, and hallucinatory experiences. They prescribed him an antipsychotic at that time, but concluded that these symptoms were best explained by post-traumatic stress they inferred from his pre-adoption life.

Most recently, Michael was weaned off risperidone to manage a new side effect of tics. He subsequently manifested growing suspiciousness with reactive aggression toward peers for imagined slights and insults that he could “swear he heard.” A different school-contracted psychologist's re-evaluation concluded that a diagnosis of psychosis was warranted based on the several years of unfolding clinical observations. Acting from the supposition that early-onset psychosis was too rare and too stigmatizing a condition to apply to a “kid who's just having trouble paying attention,” the first school psychologist remained adamant that ADHD and ASD were the most appropriate diagnoses, and Michael would be ill-served “pumped full of neuroleptics.”

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