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Review Article

Overview of Clinical Information about the Acute and Transient Psychoses Disorder

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Abstract

The temporal association between stressful life events and the onset of psychiatric disorders necessitates clinical investigation. In acute and transient psychoses (ATPD) such stressors have been considered of sufficient significance to warrant inclusion in diagnostic codification classification. The diagnosis of ATPD was stable in women over 3 years, but not in men. Outcomes in ATPD were better than in schizophrenia and similar to affective psychosis. In non-affective psychoses, favourable outcomes were a function of gender and premorbid functioning rather than acute onset and early remission. The ICD–10 criteria for ATPDs identify a diagnostically unstable group of disorders. Acute onset and early remission do not independently predict favourable outcome over 3 years in first-episode psychosis. This study examines the extent to which stressful life Events play a triggering etiologic role in ATPD. Antipsychotics like atypical antipsychotics are show better therapeutic effect in this disorder.

Keywords: Acute and transient psychosis, acute and transient psychoses Disorder, Antipsychotics, atypical antipsychotics.

Introduction

Acute and transient psychosis as a descriptive entity was recognized only recently with the advent of ICD-10[1] in 1992, where it is included under psychotic disorder (F23) as a three-digit code. The key features that characterize the disorder are an acute (within 2 weeks) onset in all the cases; presence of typical syndromes which are described as rapidly changing, variable, polymorphic states and typical schizophrenic symptoms; evidence for associated acute stress in a substantial number of cases and complete recovery in most cases within 2-3 months. Apart from these diagnostic criteria, ICD-10[1] also provides diagnostic guidelines which include:

- Not meeting the criteria for manic or depressive episodes
- Although affective symptoms may be prominent.
- Absence of organic causation although perplexity,
- Confusion and inattention may be present,
- Absence of obvious intoxication by drugs or alcohol.

It is evident that the ICD-10[1] intends to clearly differentiate the concept of ATP from those of affective psychoses, organic psychoses and drug-induced psychoses. It is also mentioned, however, that the "nomenclature of these acute disorders is as uncertain as their nosological status. "Psychotic disorder" is used as a term of convenience." The fact remains that systematic clinical information that would guide the classification of acute psychotic states is not yet available" (ICD-10). Nevertheless, four subtypes are described in ICD-10, which are represented on the fourth digit, i.e., F 23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia. F 23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia. F 23.2 Acute schizophrenia-like psychotic disorder. F 23.3 Acute predominantly delusional psychotic disorders. In the end, there are Other (F 23.8) and Unspecified categories (F 23.9) of acute psychoses. There is provision for coding the presence or absence of stress on the fifth digit. Time limits and transitions from one disorder to another

have been included to make adhoc or post hoc diagnosis of ATP as the duration criterion is an important factor. Overall, duration of the total episode should not exceed 3 months and that for schizophrenic symptoms should not exceed 1 month. There is provision for change of diagnosis to schizophrenia in case the duration of symptoms exceeds these limits.

There are some Life events are objective experiences that disrupt or threaten to disrupt an individual's usual activities, causing a substantial readjustment in that individuals behaviour (Dohrenwend & Dohrenwend, 1974). Although the basic somatic mechanisms are not understood, it is believed that such behavioural readjustments somehow trigger pathophysiologic reactions underlying mental illness. Proponents of classic concepts like 'reactive psychoses, 'bouffée délirante' or 'hysterical psychoses' claim that there is a certain variety of acute psychosis, which is always preceded by a life event. However the ICD-10 (WHO, 1992) conceptualization of acute and transient psychotic disorders (ATPD) fails to recognize this, apart from providing classifiers like "with/without" stressors. Scandinavian researchers as proponents of reactive psychosis have criticized the ICD-10 (WHO, 1992) ATPD construct as inadequate (Ungvari & Mullen, 2000). According to them, this conceptual model has only given low priority to the reactivity to stress (Jorgensen et al., 1997). This under emphasis on the triggering role of stress may not be justified in view of research evidence (Guldberg et al., 1996). Such contradicting viewpoints provide motivation for further research to clarify the possible triggering role of life events in ATPD. Studies of the psychological effects of exposure to life events by research designs employing matched controls have been comparatively rare (Thoits, 1983). Without such comparisons it is difficult to assign triggering effects to stressors in a clinically meaningful fashion. Moreover little is known about the exact duration prior to a psychotic episode during which life events might exert an influence on brain function. Researchers have suggested different time periods such as one year (Singh et al., 1983), six months (Thoits, 1983), three to four months (McCabe, 1975;Goodyer et al., 1987) or three to four weeks (Brown & Harris 1978; Paykel, 1974). In ICD-10 (WHO, 1992), classification, the duration is arbitrarily set as two weeks.By contrast, the literature is much more extensive with regard to studies on life events in affective disorders (Chung etal., 1986; Aronson & Shukla, 1987; Kendler et al., 1993; Brochier & Olie, 1993). Clinical experience suggests that in the affective disorders spectrum, the presenting clinical presentation features of manic episode often resemble ATPD (Jorgensen et al., 1997). It often requires a period of time before the presumptive diagnosis of ATPD is revised to bipolar manic disorder (Deb, 2001; Sajith et al., 2002). This diagnostic confusion is understandable. Manic patients often present with agitation, excitement, irritability, and overactivity all of which are common in ATPD (Okasha et al., 1993). Bipolar disorder research has now generated a considerable database regarding the relative role of life events in the causation of this illness. In contemplating the present investigation, it was considered that this literature would provide a useful background. It was hoped that designing a comparison study might clarify the relative importance of life events in triggering of ATPD.

ATP: A Nosological Challenge

ATP is a new entrant to psychiatric nosology and ICD-10 concept of ATP has limited validity. While knowledge is the basis of nosology and classification, nosology facilitates research and further generation of knowledge. Classification is the process by which complexity of phenomena is reduced by arranging them into categories according to some established criteria for one or more purposes. Purpose of classification is to improve treatment and prevention efforts. Ideally, classification of disorders should be based on knowledge of aetiology or Pathophysiology. However, in psychiatry, clinical-descriptive approach has been adopted as valid. When we look at the classification of major mental disorders, we find that it has been based on three major concepts and streams of thought propounded by the three most influential researchers of their time: Kraeplin (1856-1926) - who classified functional psychoses into dementia precox and manic depressive psychosis on the basis of the course and outcome of the disorders. He believed in organic causation of these conditions. Bleuler (1857-1939) - gave the term schizophrenia and described the main psychopathological mechanisms underlying the process of schizophrenia, which were mostly inferred in the form of disturbances of associative processes. Freud (1856-1939) - described neuroses and personality disorders on the basis of psychodynamic theory of personality development arising from uncon-

scious conflicts, dammedup sexual excitations (actual neurosis) and psychological defence mechanisms. Between these three schools of thought, most of the known major mental disorders were covered. They used different sets of parameters to describe these disorders. However, in contemporary psychiatry, any psychiatric diagnosis must succeed certain tests of validity given by Feighner *et al.* i.e., distinct clinical description, delimitation from other disorders, laboratory studies, follow-up studies and family genetic studies, before it can be accepted as a valid diagnostic entity worthy of inclusion in nosology and classification. Testing the concept of ATP on these tests of validity has been the major nosological challenge. Effort has been made in the paper to examine the available research data for insights and directions into the nature of ATP.

Historical Evidence

There were several reports, from several different parts of the world, of occurrence of certain psychotic states other than schizophrenia and MDP described by different names listed below:

France : Bouffee Delirante[3]
Germany : Motility Psychosis[4]
Cycloid Psychosis[5,6]
Reactive Psychosis[7]
Scandinavia : Psychogenic psychosis[8-11]
Schizophreniform Psychosis[12]
America : Remitting Schizophrenia;[13]
Good Prognosis Schizophrenia[14,15]
Hysterical Psychosis[16]
Acute Schizoaffective Psychosis[17]
Japan : Atypical Psychosis[18]
Africa : Acute Primitive Psychosis[19]
Acute Paranoid Psychosis[20]
Transient Psychosis[21]
West Indies : Acute Psychotic Reaction[22]
India : Acute Psychoses of Uncertain Origin[23]
Hysterical Psychosis[24]
Acute Psychosis without Antecedent Stress[25]
Acute Schizophrenic Episode [26]

Common features of these historical entities were:

- acute or sudden onset
- unstable, variable, fluid and florid symptomatology
- volatile polymorphic content
- anxiety
- fear or prominent affective symptoms
- association with a clear precipitant
- good premorbid adjustment
- rapid and complete recovery

These syndromes did not fit into descriptions of affective or schizophrenic disorders.

Clinical Diagnosis

The authors presented the follow-up data and assessments to a senior member of the research team (a consultant psychiatrist), with everyone involved in the diagnostic process masked to the original consensus diagnosis. All clinical information available over the 3-year follow-up period was used to determine a longitudinal diagnosis based on ICD–10 criteria for all participants, including those who were 'currently well', i.e. whose psychotic episode had ended before the follow-up assessment.

Diagnostic decision tree

A diagnostic decision tree was created as follows.

1. In cases in which no new information emerged subsequent to that used to establish the Onset diagnosis, the original diagnosis remained. This ensured that a consensus diagnosis was not made on a reinterpretation of the original data 3 years later.
2. In cases in which the ATPD-diagnosed patient subsequently developed an episode-Fulfilling ICD–10 criteria for another illness category, such as schizophrenia, affective psychosis or substance-related psychosis, the longitudinal diagnosis changed from ATPD to the subsequent diagnosis. However, cases with a non-ATPD diagnosis at onset were not recorded as ATPD on follow-up even if the patient had experienced a subsequent episode fulfilling the criteria for ATPD. The direction of any change in diagnosis was therefore always away from ATPD.

Epidemiology

Epidemiology of ATPDs the incidence rates and gender ratios given The incidence rates and gender ratios given here are age- and gender-standardised for here are age- and gender-standardised for the population of England and Wales, 1991 the population of England and Wales, 1991 census. Based on the intake consensus diag- census. Based on the intake consensus diagnosis, the annual incidence rate of ATPDs

nosis, the annual incidence rate of ATPDs was 3.90 per 100 000 population (95% CI was 3.90 per 100 000 population (95% CI 2.55 to 5.26). The rate in men was almost 2.55 to 5.26). The rate in men was almost double that in women (5.08 double that in women (5.08 v. 2.72) with a 2.72) with a male/female ratio of 1.87 (95% CI 0.90 to male/female ratio of 1.87 (95% CI 0.90 to 3.88). The overall annual incidence rate for 3.88). The overall annual incidence rate for the 'true' 3-year diagnosis of ATPDs was the 'true' 3-year diagnosis of ATPDs was much lower (1.36 per 100 000, 95% CI much lower (1.36 per 100 000, 95% CI 0.56 to 2.17) with a female preponderance 0.56 to 2.17) with a female preponderance (men: 0.74 per 100 000, 95% CI (men: 0.74 per 100 000, 95% CI 70.09 to 0.09 to 1.58; women: 1.99 per 100 000, 95% CI 1.58; women: 1.99 per 100 000, 95% CI 0.61 to 3.38; male/female ratio 0.037, 95% 0.61 to 3.38; male/female ratio 0.037, 95% CI 0.02 to 0.08). CI 0.02 to 0.08).

Signs and Symptoms

According to the DSM-IV-TR, Brief Psychotic Disorder is defined as the presence of one or more of the following symptoms lasting for at least 1 day but less than 1 month. This is accompanied by Delusions, Hallucinations, Disorganized speech (speech or thoughts that are incoherent or difficult to follow) and Grossly disorganized or catatonic behaviour

Management

The following treatment guidelines are meant as a reference tool only, and are not intended as treatment advice or to replace the clinical decision-making process of psychiatrists or other health professionals who administer these treatments. In clinical practice there are often good reasons why treatment approaches differ from what is described below. Treatments strategies specific for brief psychotic disorders have not been the focus of much research. Clinical experience would suggest that these conditions are likey to respond to the same medication strategies used for Schizophrenia. However, in the case of brief psychotic disorders the medications could probably be discontinued a few months after the episode has resolved. In now a day's most of the psychiatrists prescribe Anti psychotics especially Atypical anti psychotics like Aripiprazole Olanzepine, Quetipine, these are the most preferable drugs to effectively treat the ATPD.

Conclusion

We conclude that the differences in frequencies of different type of life events preceding ATPD, as contrasted with mania. It might be inferred that life events might be more important in as triggering events in ATPD than is generally recognized. The apparent rationale for the popular use of high doses of narcoleptics in psychotic patients is to increase the degree and speed of therapeutic response. However; several recent reports have questioned these claims. For the better therapeutic outcome most of the physicians effectively use the atypical antipsychotics like Aripiprzole, Olanzepine, Qeutipine.

Abbreviations

ICD 10 - International Classification of Diseases.
ATPD - Acute and Transient Psychoses.
WHO -World Health Organization.

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