"DESCRIPTION OF SYMPTOMATOLOGY AND PHENOMENOLOGY OF ACUTE AND TRANSIENT PSYCHOTIC DISORDER: A ONE YEAR HOSPITAL BASED CROSS-SECTIONAL STUDY"

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DR. S.S. CHATE MD, DPM
Professor and HOD
Department of Psychiatry,
J. N. Medical College,
Belagavi, Karnataka

Dr. S. S. CHATE
Professor & Head
Dept. of Psychiatry
J.N. Medical College, BELGAVI - 590 010
KMC Reg No. 46918

Date: 8/7/24
Place: Belagavi.

DR.(Mrs) N. S. Mahantashetti MD (Paed).
Principal
J. N. Medical College,
Belagavi, Karnataka.

PRINCIPAL
JAWAHARLAL NEHRU MEDICAL COLLEGE
BELAGAVI

Date: 8/7/24
Place: Belagavi.

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Accredited 'A+' Grade by NAAC (3rd Cycle) **Placed in Category 'A' by MoE (GoI)**

Nehru Nagar, Belagavi- 590 010, Karnataka, INDIA

0831 - 2471350 0831 - 2470759 www.jnmc.edu principal@jnmc.edu

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Dr. (Mrs.) N.S. Mahantashetti.
Chairperson-Antiplagiarism Committee &
Principal,
J. N. Medical College, Belagavi.

To,
Reg. No. BQ0121002
Postgraduate Student,
2021-22 Batch,
Department of Psychiatry
J. N. Medical College, Belagavi.

K.L.E. ACADEMY OF HIGHER EDUCATION AND RESEARCH
(Deemed to be University)
Accredited 'A+' Grade by NAAC in (3rd Cycle) Placed in Category 'A' by MHRD (Govt.)
JNMC INSTITUTIONAL ETHICS COMMITTEE
JAWAHARLAL NEHRU MEDICAL COLLEGE,
NEHRU NAGAR, BELAGAVI-590010 (KARNATAKA-INDIA)
Website: http//www.jnmc.edu
E-Mail : dome@jnmc.edu
Phone: (+ 91-(0)831 Office : 2472550
Principal: 2471701
Fax No. +91 (0)831 – 2470759

Ref No.MDC/JNMCIEC/ 106 **Date: 27/09/2022**

To,

BQ0121002
PG Student in Psychiatry,
J. N. Medical College,
BELAGAVI.

Sub: Institutional Ethical Clearance for the study.

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(Dr. Smita Sonoli)
Member Secretary
JNMC Institutional Ethics Committee
J.N.Medical College, Belagavi.

(Dr. Harsha Hegde)
Chairman,
JNMC Institutional Ethics Committee
J.N.Medical College, Belagavi

LIST OF ACRONYMS

ICD-11	International Classification of Diseases-11
DSM-V	Diagnostic and Statistical Manual of Mental Disorder-V
DSM-IV	Diagnostic and Statistical Manual of Mental Disorder-IV
ICD-10	International Classification of Diseases-10
ATPD	Acute and Transient Psychotic Disorder
MSE	Mental Status Examination
BPRS	Brief Psychotic Rating Scale
GAF	Global Assessment of Functioning Scale
ICMR	Indian Council of Medical Research
WHO	World Health Organisation
IPSS	International Pilot Study of Schizophrenia
DOSMeD	Determinants of Outcome of Severe Mental Health Disorders
SES	Socio-Economic Status
NARP	Non-affective, Acute, Remitting Psychosis
MHCA	Mental HealthCare Act,2017
PI	Principal Investigator
CAP	Cross-cultural Study of Acute Psychosis
IPD	Inpatient Department
OPD	Outpatient Department

ABSTRACT

Introduction: Acute and transient psychotic disorders (ATPDs) are characterized by the abrupt onset of psychotic symptoms within a two-week period, often triggered by stressors, and typically resolve within a few months. Despite their clinical significance, the prevalence of ATPD in the general population is not well-defined. Previous studies have shown varying symptom presentations, emphasizing the need for further investigation into ATPD's clinical features and diagnostic subtypes.

Objectives

1. To describe the symptomatology and phenomenology in patients of acute and transient psychotic disorder.
2. To describe the diagnostic subtypes of ATPD.

Method: This cross-sectional study was conducted in the Department of Psychiatry, KLES Prabhakar Kore Hospital from January 1 to December 31, 2023. It included 60 patients above the age of 18 years who met the ICD-10 criteria for ATPD, excluding those with substance use disorders, intellectual disability, or organic psychosis. The study involved both inpatient and outpatient settings, focusing on socio-demographic variables, symptom profiles, and diagnostic subtypes.

Results: The majority of participants were in the 21-30 years age group with an average age of 37.23 ± 14.95 years. Females constituted 76.67% of the study population. Most participants had primary education, and a significant proportion were from rural areas. Common symptoms included delusions, hallucinations, and affective disturbances. The study highlighted a notable gender disparity and a higher prevalence of ATPD among individuals from lower socio-economic backgrounds.

Conclusion: The findings emphasize the diverse clinical presentation of ATPD and the potential influence of socio-demographic factors on its prevalence. The study underscores the importance of detailed exploration of ATPD's phenomenological aspects to facilitate accurate diagnosis and effective treatment strategies. Further research is needed to establish a clearer picture of ATPD prevalence and its socio-demographic correlates across different settings.

Keywords: ATPD, acute psychosis and symptomatology, clinical features and acute psychosis.

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INTRODUCTION

Acute and transient psychotic disorders (ATPDs) emerged formally in the medical taxonomy with the introduction of the International Classification of Diseases, 10th edition (ICD-10) in 1992,[1] later acknowledged in the DSM-IV[2] in 1994 under the label "Brief Psychotic Disorders," a classification retained in the DSM-5.[3] These disorders are characterized by the abrupt onset of symptoms within a two-week period, featuring rapidly fluctuating psychotic manifestations. Symptoms often mimic those of schizophrenia, typically triggered by recent stressors, and commonly resolve within two to three months. Specific diagnostic criteria differentiate ATPD from psychoses associated with mood disorders, physical ailments, or substance use.[4]

Despite its clinical significance, the prevalence of ATPD in the general population remains inadequately defined, with scant data available from diverse healthcare contexts.[5]Early studies, such as one conducted by the Indian Council of Medical Research across four centres (Patiala, Bikaner, Goa, and Vellore) several decades ago, indicated that approximately 8.7% of first-episode psychosis cases might align with acute psychosis criteria.[6] Subsequent research estimated annual ATPD prevalence in India ranging from 3.9 to 9.6 cases per 100,000 individuals.[7,8]

Detailed exploration of ATPD's phenomenological aspects remains sparse, necessitating further investigation into its clinical features and diagnostic subtypes. Prior research highlights varying symptom presentations among ATPD patients. For instance, studies in North India by Singh et al.[9] emphasized delusions, hallucinations, poor rapport, lack of insight, and concrete thinking as prominent features. Similarly, research in Central India by Mishra et al.[10] identified delusions, abnormal speech, hallucinations, and disorganized behaviour as prevalent symptoms in first-episode psychosis patients. Conversely, investigations like Marneros et al.'s[11] study in

Germany underscored high occurrences of delusions, hallucinations, delusion of control, first-rank symptoms, and affective disturbances among ATPD cases.

However, existing literature often lacks comprehensive descriptions of ATPD's specific symptomatology and phenomenological nuances, underscoring the need for more detailed research to facilitate accurate diagnosis and effective treatment strategies. Also, to the best of our knowledge such detailed studies have not been in a general hospital setting in North Karnataka. This study to the best of our knowledge, is a first of a kind study that aims to address this gap by providing a comprehensive exploration of ATPD symptomatology and phenomenology among patients in a general hospital setting in North Karnataka.

OBJECTIVES

- To describe the symptomatology and phenomenology in patients of acute and transient psychotic disorder
- To describe the diagnostic subtypes of ATPD

REVIEW OF LITERATURE

The concept of acute and transient psychosis (ATPD) as a distinct diagnostic category is relatively recent. It was introduced in the International Classification of Diseases, 10th edition (ICD-10) in 1992, classified under psychotic disorders (F23). This category is recognized in both ICD-10 as "Acute and Transient Psychotic Disorders"[1] and in DSM-IV,[2] and retained in DSM-5, as "Brief Psychotic Disorders," which are distinct from schizophrenia and affective psychoses.[3]

PREVALENCE:

However, community-based studies have not clearly established the prevalence of ATPD in the general population, and data on its prevalence across various healthcare settings remain limited.[12] An Indian Council of Medical Research study conducted four decades ago across four Indian centres (Patiala, Bikaner, Goa, and Vellore) provided initial insights. This study, which examined 323 patients with first-episode psychosis, suggested that 8.7% could be classified under acute psychosis in the Indian context.[6] Another study indicated an annual prevalence range of 3.9 to 9.6 cases per 100,000 population in India. [13] Some recent studies focus on specific populations rather than explicitly targeting ATPD prevalence. For example, a Chandigarh study found a 2.26% prevalence of ATPD among new adult outpatients, [14] and a Ranchi study reported a 1.7% prevalence among patients with affective and non-affective psychosis. [15] Studies on inpatients have shown a prevalence of 3.2%. [16] While these findings offer initial insights, further research is needed to establish a clearer picture of ATPD prevalence across various settings.[12]

NOSOLOGICAL ISSUE:

The concept of ATPD and related diagnoses has historically been controversial, challenging the traditional Kraepelinian classification system.[5]The nomenclature and classification of these acute disorders are as uncertain as their nosological status, raising questions about their distinctiveness and validity. Despite its official recognition in 1992, the understanding and delineation of ATPD remain unclear, and its validity has been a subject of ongoing research and debate. Due to controversies over its nosological status, ATPD has been a focus during the revisions of ICD-11 and DSM-5.

ICD-10 acknowledges that the naming and classification of these sudden-onset disorders remain unclear, admitting that "psychotic disorder" is used as a provisional term. This reflects the lack of a robust system for classifying acute psychotic states based on consistent clinical data.[1] In contemporary psychiatry, establishing a valid diagnosis requires specific criteria, including a clear clinical description, differentiation from other disorders, potential laboratory findings, long-term course through follow-up studies, and exploration of familial and genetic links. Only when these criteria are met can a condition be considered a distinct entity within diagnostic classification systems. [17]

The major nosological challenge for ATPD involves demonstrating its validity through established criteria, [5]making its nomenclature status as uncertain as its nosological status. [18]This has been a major subject of research since the 1980s, with significant insights provided by developing countries like India, where ATPD is more prevalent.[5] There is growing empirical evidence suggesting that acute brief psychoses exhibit distinctive epidemiological characteristics [19]and a benign long-term course[20], supporting the concept of ATPD as a distinct nosological entity.[21]

Despite its uncertain status in official psychiatric nosological systems, ATPD remains relevant in developing countries like India due to its diverse manifestations, progression, and eventual outcomes.

CRITERIA:

Acute and transient psychotic disorder is classified under F23 (psychotic disorders) in the ICD-10. [1] Here's a breakdown of its key features:

Rapid Onset: Symptoms develop suddenly, within two weeks of the first noticeable sign.

Psychotic Symptoms: These can be variable and change quickly (polymorphic), or they may resemble symptoms of schizophrenia, such as delusions or hallucinations. In some cases, predominantly delusional syndromes may be present.

Not Stress-Induced: Unlike some other psychotic experiences, acute and transient psychosis isn't necessarily triggered by a significant stressor.

Full Recovery Expected: The defining characteristic of this disorder is complete recovery within 1-3 months. This distinguishes it from schizophrenia (F20) and persistent delusional disorder (F22), where symptoms persist for a longer duration. [1]

Beyond these core criteria, ICD-10(1) offers additional guidelines:

- The symptoms don't meet the criteria for manic or depressive episodes, even though emotional fluctuations might be prominent.
- There's no evidence of a physical cause, despite potential confusion or inattentiveness.
- Intoxication from drugs or alcohol is ruled out.

EVOLUTION OF CONCEPT:

From the late 1800s to the mid-1900s, numerous authors in different parts of the world documented an acute-onset psychotic illness. The ICD-10 category of acute and transient psychotic disorder acts as an umbrella term, encompassing various historical concepts from around the world. These include the following among others:

France	Bouffée délirante
Germany	Motility Psychosis Cycloid Psychosis Reactive Psychosis
Scandinavia	Psychogenic psychosis Schizophreniform Psychosis
America	Remitting Schizophrenia Good Prognosis Schizophrenia Hysterical Psychosis Acute Schizoaffective Psychosis
Japan	Atypical Psychosis
Africa	Acute Primitive Psychosis Acute Paranoid Psychosis Transient Psychosis
West Indies	Acute Psychotic Reaction
India	Acute Psychoses of Uncertain Origin Hysterical Psychosis Acute Psychosis without Antecedent Stress Acute Schizophrenic Episode

There gave evidence that another psychotic illness existed that was unlike schizophrenia or affective disorders[5], some are described below:

- **German cycloid psychosis:**[22]This concept focused on rapid-onset, short-lived psychotic episodes.
- **French Bouffée délirante:** [8,23] Similar to the German concept, it described sudden, transient psychotic states.
- **Scandinavian psychogenic/reactive psychosis:** [24,25] This emphasized the potential link between psychological stress and psychotic episodes.
- **American remitting schizophrenia/good prognosis schizophrenia:**[19]These terms focused on schizophrenia-like symptoms with a favourable outcome.
- **Japanese atypical psychosis:**[26,27] This concept described unusual, short-lived psychotic episodes.

The remarkable similarities between these historical diagnoses from different cultures paved the way for the development of the current ICD-10 category of acute and transient psychotic disorder.[18,26]

.**Bouffée Délirante : A Brief Psychotic Episode:**

The term "Bouffée délirante" (French for "delirious outburst") refers to a specific type of psychotic episode recognized by French psychiatrists Valentin Magnan (1835-1916) and Paul-Maurice Legrain (1860-1939) in 1895. Originally linked to the 19th-century concept of degeneration, it's still used by French-speaking clinicians in Europe, West Africa, and the Caribbean. Here's what characterizes Bouffée délirante:

- **Acute Onset:** Symptoms appear suddenly, with no prior history of mental illness.
- **Complete Remission:** The episode fully resolves with no lasting symptoms.
- **Psychotic Features:** The episode involves delusions (false beliefs), hallucinations (sensory experiences without external stimuli), and potentially depersonalization (feeling detached from oneself) or derealization (feeling detached from reality).
- **Confusion and Mood Swings:** The episode can also involve confusion and rapid mood changes.
- **Shifting Symptoms:** The specific symptoms may vary throughout the episode.

While Bouffée délirante shares some similarities with Acute and Transient Psychotic Disorder (ATPD) in the ICD-10, it's not an official diagnostic term within the system. However, the concept helps highlight a particular presentation of brief psychosis. [8,23]

Cycloid Psychosis: A European Perspective

The concept of cycloid psychosis, though not included in major diagnostic systems like the DSM-5 or ICD-10, remains relevant for some European psychiatrists, particularly in Germany and Scandinavia. Originally described by Karl Kleist (1879-1960), it encompasses a spectrum of psychotic presentations with distinct characteristics.

Kleist's Variants:

- **Confusional Insanity:** This variant feature alternating phases of agitated confusion and stupor.
- **Motility Psychosis:** This variant involves contrasting periods of hyperactivity (hyperkinesis) and lack of movement (akinesis).

Later Additions:

Karl Leonhard (1904-1988) further expanded the concept by introducing the anxiety-elation variant, characterized by contrasting states of extreme anxiety and elation.

Key Features:

- **Acute Onset and Recurrence:** Episodes typically begin abruptly and may recur frequently.
- **Prognosis:** Despite recurrences, cycloid psychosis is generally considered to have a good prognosis.
- **Diverse Symptoms:** Episodes can involve confusion, delusions that don't necessarily match the mood (mood-incongruent), hallucinations, intense anxiety or euphoria, movement disturbances (akinetic or hyperkinetic), preoccupation with death, and rapid mood swings with symptoms changing significantly within an episode.

While the concept of cycloid psychosis is debated, it offers a framework for understanding a specific type of recurrent, brief psychosis with a favourable outcome. [28,29]

Reactive or Psychogenic Psychosis: A Historical Concept

The terms "reactive psychosis" and "psychogenic psychosis" were first introduced in the early 20th century.

- **Karl Jaspers** is credited with initially defining the syndrome in 1913.
- **Wimmer** further elaborated on the concept as "psychogenic psychosis" in 1916.

These diagnoses were particularly popular among Scandinavian psychiatrists during the first half of the 20th century. They proposed a specific type of psychosis characterized by:

Acute Onset Following External Stress: Symptoms develop suddenly, often triggered by a significant external stressor.

Affective and Confusional Symptoms: The prominent features tend to be mood disturbances, confusion, and disorientation, with less emphasis on the bizarre delusions and hallucinations often seen in schizophrenia.

Distinctive Characteristics Compared to Schizophrenia: Onset in reactive psychosis is typically acute, may occur later in life, and often presents with better premorbid functioning (functioning before the episode). Additionally, there's a lower likelihood of a family history of schizophrenia.

Favourable Prognosis: The overall course of reactive psychosis is generally considered to be better than that of schizophrenia.

While these terms are no longer used in current diagnostic systems like the DSM-5 or ICD-10, the historical concept of reactive/psychogenic psychosis highlights the potential role of psychological stressors in triggering psychotic episodes. Some aspects of this concept are reflected in the current category of Acute and Transient Psychotic Disorder (ATPD) within the ICD-10. [30]

Schizophreniform Disorder: A Diagnostic Term with Historical Roots [31]

The concept of a schizophrenia-like illness with a shorter duration has its origins in the work of Norwegian psychiatrist Gabriel Langfeldt (1937-1966). Langfeldt introduced the term "schizophreniform psychosis" to describe a condition with several key features:

- **Sudden Onset:** Symptoms appear abruptly.
- **Identifiable Precipitating Factor:** Often triggered by a clear external stressor.
- **Good Outcome:** Individuals with this condition tend to recover well.
- **Well-Adjusted Premorbid Personality:** People typically functioned well before the episode.
- **Mood Disturbances and Clouding of Consciousness:** These are prominent features alongside psychotic symptoms.

While the specific concept Langfeldt proposed wasn't directly incorporated into major diagnostic systems, the **term "schizophreniform disorder"** was adopted by the DSM-III. In the DSM-III, schizophreniform disorder is defined by the presence of psychotic symptoms that meet criteria for schizophrenia, but with a crucial difference: the duration of symptoms is **less than 6 months**. This distinction from schizophrenia remains a core feature of the disorder in current diagnostic manuals. [31]

Oneirophrenia: A Dreamlike Psychosis

In 1939, Ladislas von Meduna (1896-1964) coined the term "oneirophrenia," referring to a distinct form of psychosis distinguished by several defining characteristics:

- **Acute Onset:** Symptoms develop suddenly.
- **Dreamlike Quality:** Perceptions in oneirophrenia exhibit a surreal, dreamlike, or nightmarish quality, blurring the boundary between reality and fantasy. The term originates from the Greek "oneiros" (dream) and "phren" (mind), reflecting this characteristic.
- **Intense Emotions:** The dreamlike state is often accompanied by extreme fear and anxiety.

- **Delusions and Hallucinations:** False beliefs and sensory experiences can also be present, particularly visual hallucinations.
- **Favourable Prognosis:** Oneirophrenia is generally considered to have a good prognosis, with full recovery expected in many cases.

Interestingly, Meduna proposed an endocrinological explanation for the syndrome, suggesting a hormonal basis for its development. However, this theory is no longer widely held.

While oneirophrenia is not currently diagnostic category in major systems like the DSM-5 or ICD-10, the concept helps describe a particular presentation of psychosis with a dreamlike quality and a favourable outcome. [32]

Hysterical Psychosis: A Controversial Historical Concept

The term "hysterical psychosis" refers to a group of disorders described by Hollander and Hirsch that is no longer included in major diagnostic systems like the DSM-5 or ICD-10. It was characterized by:

- **Sudden and Dramatic Onset:** Symptoms manifested suddenly and with significant intensity.
- **Stressful Precipitant:** The onset was often linked to a significant stressful event.
- **Histrionic Personality Features:** Traits of histrionic personality include theatricality, seeking attention, and exaggerating emotions. (Note: The DSM-5 still includes "histrionic personality disorder," although it is not necessary for any other diagnosis.)
- **Psychotic Symptoms:** The core feature was the presence of psychotic symptoms, including hallucinations (false sensory experiences), delusions (fixed false beliefs), and depersonalization (feeling detached from oneself). Disorganized behaviour might also be present.

- **Short Duration:** Episodes of hysterical psychosis were believed to be short-lived, typically lasting less than 3 weeks.

The concept of hysterical psychosis has been controversial for several reasons. Some critics argued that it was poorly defined and overlapped with other diagnoses. Additionally, the association with histrionic personality was seen as stigmatizing.

While the term itself is no longer used, the concept of brief, stress-related psychotic episodes has evolved into the current category of Acute and Transient Psychotic Disorder (ATPD) within the ICD-10[33].

However, though the evidence of existence of ATPD has been present since decades, validity of the disorder was given to it by certain landmark studies that were conducted throughout the world:

THE INTERNATIONAL BACKING OF ACUTE AND TRANSIENT PSYCHOTIC DISORDER (ATPD)

The concept of Acute and Transient Psychotic Disorder (ATPD) gained credibility through international research efforts spearheaded by the World Health Organization (WHO). Here's a look at three key WHO studies that played a crucial role:

International Pilot Study of Schizophrenia (IPSS) (1968-1970): This large-scale study examined schizophrenia across various countries. While its primary focus was schizophrenia, it also helped identify and differentiate cases of brief psychotic episodes, laying the groundwork for ATPD[34,35].

Determinants of Outcome of Severe Mental Health Disorders (DOSMeD): This WHO initiative aimed to understand factors influencing the outcome of severe mental illnesses. Though not exclusively focused on ATPD, DOSMeD likely included cases with brief psychotic presentations, contributing to a broader understanding of these disorders[36].

Cross-cultural Study of Acute Psychosis (CAP) (1980-1982): This targeted research specifically investigated acute psychosis across cultures. CAP's findings provided strong evidence for the existence of a distinct category of short-lived psychotic episodes, separate from both schizophrenia and mood disorders[5,37].

The combined results of these WHO studies significantly bolstered the validity of ATPD as a recognizable clinical entity. They demonstrated the occurrence of acute-onset psychotic experiences that differed from schizophrenia and other mental health conditions. This international backing played a major role in solidifying the concept of ATPD within diagnostic frameworks[12].

DISCUSSION ON ATPD:

The International Pilot Study of Schizophrenia (IPSS) yielded interesting insights[34]:

- **Favourable Outcomes:** A noteworthy finding was that a significant portion (26%) of the schizophrenia subjects experienced a relatively good outcome, characterized by having only a single episode.
- **Global Disparity:** The study also suggested a possible influence of geographical location on outcome, with patients from developing countries potentially faring better.

This information sheds light on the heterogeneity of schizophrenia presentations and the potential role of external factors in influencing illness course[38].

The WHO-led DOSMED study (Determinants of Outcome of Severe Mental Health Disorders) made significant contributions to our understanding of psychosis[36]:

- **Identification of Non-Affective Remitting Psychosis:** The study identified a specific group of patients experiencing psychosis that wasn't related to mood disorders (affective psychosis). These patients had a complete recovery, and DOSMED termed this condition "non-affective, acute, remitting psychosis" (NARP).
- **Higher Prevalence in Developing Countries:** Interestingly, DOSMED data revealed a tenfold increase in NARP cases within developing countries compared to developed nations[39].

These findings suggest the existence of a distinct psychotic disorder with favourable outcomes, and they raise questions about potential social or environmental factors influencing its prevalence across different regions.

The Cross-Cultural Study of Acute Psychosis (CAP) provided valuable insights into the characteristics and outcomes of acute psychosis[35,37]**:**

- **Heterogeneity of Symptoms:** The study revealed a diverse presentation of symptoms among patients with acute psychosis. A significant portion (41.2%) displayed symptoms characteristic of schizophrenia, while 20% exhibited symptoms more aligned with mood disorders (affective symptoms), and 35.3% presented with other types of psychotic symptoms. This emphasizes the diverse clinical presentation of acute psychosis.
- **Stress as a Potential Trigger:** Interestingly, the CAP study found that over 41.7% of patients with acute psychosis reported experiencing significant stress close to the onset of the episode. This underscores the wide-ranging clinical manifestations of acute psychosis.

- **Socioeconomic Disparity:** The study also identified a notable trend: a higher prevalence of acute psychosis among patients from lower socio-economic backgrounds. This discovery justifies additional exploration into the possible social factors influencing mental health.
- **Favourable Prognosis:** A positive outcome was observed, with two-thirds of the patients (approximately 66.7%) remaining well and relapse-free after one year. This suggests that acute psychosis can have a favourable course for many individuals[37].

The CAP study's findings offer valuable information about the complexities of acute psychosis, highlighting the diverse presentations, potential triggers, and the possibility of recovery.

ICMR study on acute psychosis[6,40]:

A collaborative study conducted by the Indian Council of Medical Research (ICMR) across four centres in India (Bikaner, Goa, Patiala, and Vellore) investigated the characteristics and natural course of acute psychosis. The study's key finding was particularly noteworthy:

- **Diagnostic Challenges:** A substantial number of cases (52%) did not fit neatly into current diagnostic categories.

This finding highlights the potential limitations of current diagnostic frameworks in capturing the full spectrum of acute psychosis presentations[33].

The Chandigarh Acute Psychosis Study[40,41]:

This significant study explored the diagnostic challenges in acute psychosis. Researchers found that:

- **Limited Fit Within Existing Diagnoses:** Only 60% of the cases studied with acute psychosis met the criteria for schizophrenia or mood disorders as per the prevailing ICD-9 classification system, indicating a restricted alignment with existing diagnoses.
- **A High Proportion of Non-Categorical Cases:** A substantial 40% of cases didn't neatly fit into established diagnostic categories for schizophrenia or mood disorders. These cases could potentially be classified as "acute psychosis" under a distinct diagnostic category[42].

This study's findings echo those of the ICMR study, highlighting the limitations of existing diagnostic systems in capturing the full range of presentations in acute psychosis[34].

ACUTE AND TRANSIENT PSYCHOTIC DISORDER (ATPD) IN ICD-10:

The ICD-10 classification for ATPD (F23) has the following subtypes:

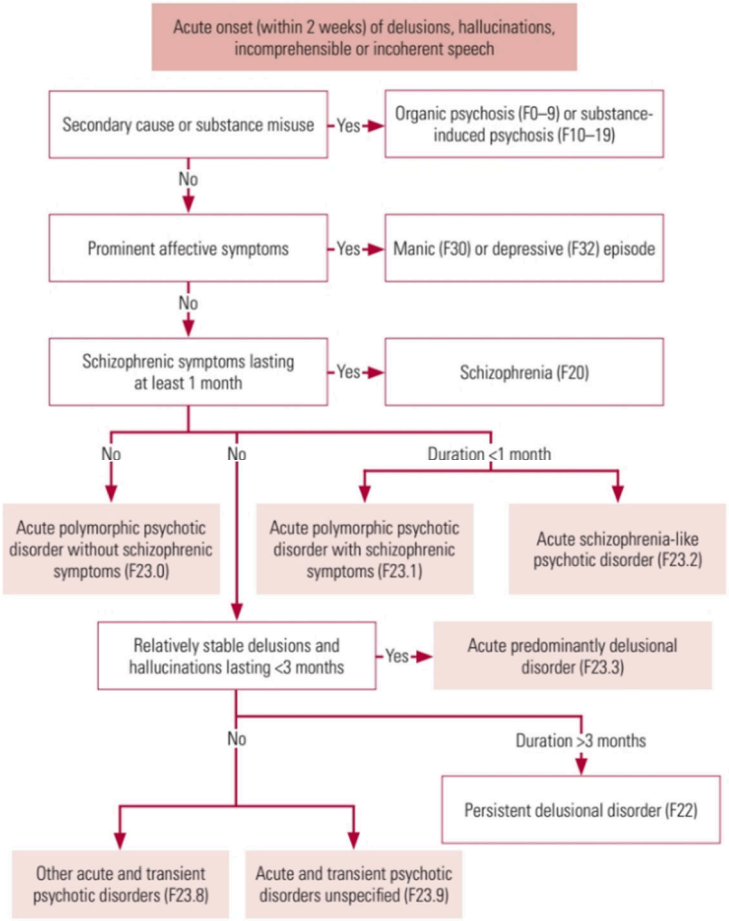


Figure 1: Shows subtypes of ATPD describes by ICD-10[1,18]

F23 ATPDs	Symptoms	Duration	Exclusion
F23.0 Acute polymorphic disorder without schizophrenic symptoms	Delusions, hallucinations, perceptual changes, emotional turmoil (*i.e.*, feelings of happiness and ecstasy or anxiety and irritability) shifting daily or even faster	<3 mo	Organic disease, alcohol and drug intoxication, manic disorder, depressive disorder, schizophrenia
F23.1 Acute polymorphic disorder with schizophrenic symptoms	Polymorphic and rapidly changing clinical picture plus schizophrenic symptoms	<1 mo	Organic disease, alcohol and drug intoxication, schizophrenia, acute polymorphic disorder
F32.2 Acute schizophrenia-like psychotic disorder	Relatively stable psychotic symptoms	<1 mo	Organic disease, alcohol and drug intoxication, schizophrenia, acute polymorphic disorder
F23.3 Other acute predominantly delusional disorders	Relatively stable delusions or hallucinations	<3 mo	Organic disease, alcohol and drug intoxication schizophrenia, acute polymorphic disorder
F23.8 Other acute and transient psychotic disorders	Acute psychotic disorders not classifiable under any other F23 category	<3 mo	–
F23.9 Acute and transient psychotic disorder unspecified	Any acute psychotic disorders unspecified	<3 mo	–

Acute onset is defined as a change from a state without psychotic symptoms to a clearly psychotic state within 2 weeks or less; it is also possible to specify "abrupt onset within 48 hours."

A fifth character may be used to indicate whether ATPDs are associated with "acute stress" (F23. X1/0).

Figure 2 : Nomenclature as introduced by ICD-10[43]

SOCIODEMOGRAPHIC PROFILE:

Early research suggested a potential female predominance and a higher prevalence in rural areas [6,41,44] Age of participants also shows a significant spread, ranging from 21.3 to 37.67 years [45,46] and educational attainment varies from 7.11 to 13.95 years [47,48]. The percentage of the married people in different studies has ranged from 11.8% [49] to 91.6%[46].

FAMILY STUDIES:

A study, Das et al. (1999)[50] compared the familial risk patterns of Acute Transient Psychotic Disorder (ATPD) and schizophrenia. Interestingly, the researchers found that first-degree relatives of individuals with ATPD had a higher prevalence of ATPD compared to relatives of those with schizophrenia. This suggests that ATPD may have a distinct genetic risk profile compared to schizophrenia[51].

Das et al. (2007)[51] investigated the characteristics of family history in relation to ATPD. Their study found no significant differences in sociodemographic or clinical features between patients with a positive and negative family history for mental illness. However, when examining siblings of individuals with first-episode psychosis (FEP), they observed a high prevalence (57%) of schizotypal traits, particularly among females who displayed a greater tendency towards magical thinking, paranoia, unusual behaviour, and social anxiety[50].

SYMPTOMATOLOGY

Symptom profile is varied across different studies. However, some studies are listed below:

AUTHOR	YEAR OF STUDY	TYPE OF STUDY	RESULTS
Kumar et al. [13]	2013	Cross-sectional study	A study involving 50 patients with ATPD found that symptoms like suspiciousness, hallucinations, unusual thoughts, and uncooperativeness to be present in more participants. Anxiety and grandiosity were also present, but to a lesser degree.
Singh et al. [9]	2020	Cross-sectional observational study	A study investigating ATPD found that most patients were females between 15-35 years old, with an average age of 32.45. The majority were educated, married, unemployed, lived in nuclear families, and had rural backgrounds. However, around 75% of the patients reported experiencing stressors before the episode. The study also revealed that females scored higher on a measure of overall psychopathology (PANSS). In terms of symptoms, sleep problems, delusions, hallucinations, difficulty building rapport, lack of self-awareness, and concrete thinking were most commonly observed.

Rajkumar R.P. et al.[52]	2016	Retrospective chart review	In this study, the author took 46 patients which were divided into patients having acute polymorphic psychotic disorder (APPD) and the half with non-APPD, he found that both groups had a female preponderance, most were married. Most participants had age between 24-27 years. Patient presented most with delusions (among which persecution , followed by reference was most common), followed by irritability and perceptual disturbances. Lability, depressive symptoms, catatonic symptoms were also found to be present in a lot of patients. Some had formal thought disorders and perplex mood. Small sample had suicidality
Chavan and Kulhara et al. [53]	1988	Follow up study	22 patients who met the diagnostic criteria were studies, scales like Comprehensive Psycho-pathological Rating Scale (CPRS)(49) was used for assessing manifest psychopathology. Evaluation of First Rank Symptoms (FRS) with criteria given by Schneider(50). It was found that sleep impairment and decreased appetite was the most common chief complaint (90%). 86% had difficulty in concentrating. Disturbances in mood and affect

			were very common-sadness being maximum. 72% were hostile. Delusions were present in 87%. 68% has delusion of persecution. Rest had grandiosity, morbid jealousy or hypochondriasis. 63% has hallucination among which auditory were more. Some patients had somatic passivity and 2nd person auditory hallucinations.
Marneros et al. [11]	2005	Follow up study	Hallucinations (76.2%) and delusions were present in (97.6%) of the sample. Affective disturbances in 100% sample of which depressed mood was 73.8% and anxiety 77% and thought disorders in 85.7% were present.

MATERIAL AND METHODS

This study was designed as an observational study, to analyse the demographic data and symptomatology in patients diagnosed with ATPD. It was conducted at the Department of Psychiatry in a General Hospital over a period of one year from 1st January 2023 to 31st December 2023. The source of the sample were patients above the age of 18 years who attended the outpatient department of the department of psychiatry and those who were admitted to psychiatry free ward.

Inclusion Criteria:

- Patients above the age of 18
- All patients with a diagnosis of acute and transient psychotic disorder

Exclusion Criteria:

- Psychotic disorders secondary to general medical condition and neurological disorders
- Psychotic disorder in the presence of known intellectual disability
- Substance induced psychotic disorder

Ethical clearance:

Before starting the study, approval was granted by the institutional ethics committee of Jawaharlal Nehru Medical College, Belagavi, under clearance number MDC/JNMCIEC/106.

Informed Consent:

Consent was obtained from the family members or caregivers of patients who met the inclusion criteria.

Sample size:

Purposive sampling done

Sample size:

Based on the formula,

$$Sample\ size = n = \frac{E^2.p.(1-p)}{E^2}$$

Z is the Z-score corresponding to the desired confidence level (e.g., 1.96 for 95% confidence).

p is the estimated prevalence (proportion).

E is the margin of error (desired precision).

Here, at 95% confidence, the Z-score (Z) is 1.96.

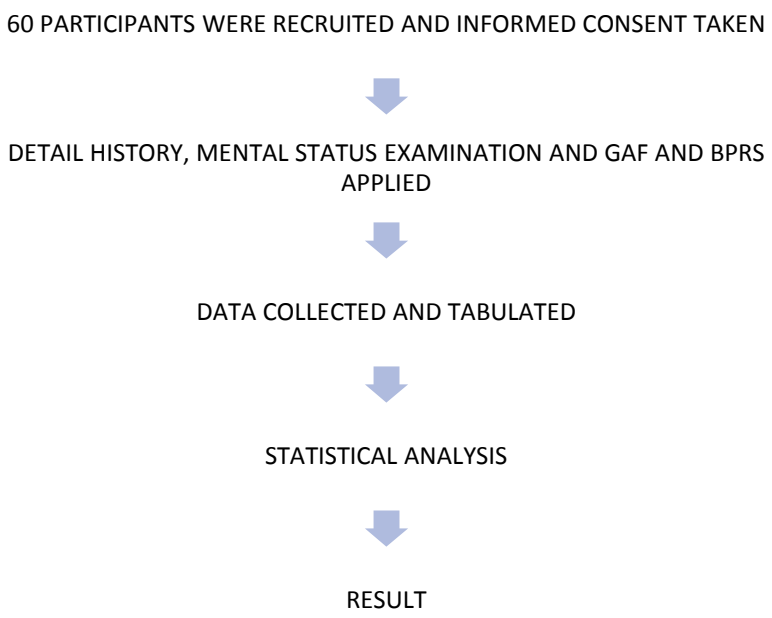
Prevalence (p) is taken as 0.115 (11.5%).

Margin of error (E) is 0.08

Therefore, the sample size was obtained as 62

We approximated the sample size to 60

PROCEDURE:



The Principal Investigator (PI) conducted interviews with patients diagnosed with Acute and Transient Psychotic Disorder (ATPD) and their caregivers. During these interviews, the PI explained the study's purpose, procedures, and implications to ensure participants fully understood the research. Participants who satisfied both the inclusion and exclusion criteria were chosen for the study. Written informed consent was obtained from both caregivers and patients, who were admitted under high support as per Section 89 of the Mental Healthcare Act (MHCA), 2017[54]. The consent forms were provided in the caregivers' vernacular language to ensure clarity and understanding. This measure ensured that participants willingly agreed to take part in the study and were informed about their rights. The participants who were recruited were assessed within the first 48 hours of contact with the Department of Psychiatry. A detailed proforma was utilized to gather socio-demographic information and clinical characteristics of the participants. A comprehensive Mental Status Examination (MSE) was performed to evaluate the patient's current mental state. This included observations and inquiries about appearance, behaviour, mood, thought processes, cognition, and insight. The study utilized the Brief Psychiatric Rating Scale (BPRS)[54] to evaluate symptoms like depression, anxiety, hallucinations, and unusual behaviour. Additionally, the Global Assessment of Functioning (GAF) scale[55] assessed the patient's overall psychological, social, and occupational functioning. This methodical approach ensured a comprehensive evaluation of each participant, yielding a complete dataset for analysis. Subsequently, the data was organized, tabulated, and analysed.

TOOLS:

Global Assessment of Functioning (GAF) scale:[55] The Global Assessment of Functioning (GAF) Scale assesses an individual's overall psychological, social, and occupational functioning, with scores ranging from 0 to 100. Higher scores indicate higher levels of functioning.

Brief Psychiatric Rating Scale (BPRS):[54]The Brief Psychiatric Rating Scale (BPRS) is employed to assess the severity of psychiatric symptoms, focusing on conditions like schizophrenia and other psychotic disorders. Created in the 1960s, the BPRS comprises 18 to 24 items, each rated on a scale from 1 (not present) to 7 (extremely severe).

DATA ANALYSIS:

Data obtained was tabulated and analysed with percentages for categorical variables and standard deviation for continuous variables.

RESULTS

Table 1: Distribution of participants according to Sociodemographic details (N=60):

Age group	Number of patients (N=60)	Percentage (%)
≤20 years	8	13.33
21-30 years	17	28.34
31-40 years	15	25
41-50 years	9	15
51-60 years	6	10
>60 years	5	8.33
Gender		
Female	46	76.67
Male	14	23.33
Education		
Illiterate	9	15
Primary	34	56.67
Middle	11	8.33
Graduate	6	10
Domicile		
Rural	35	58.33
Urban	25	41.67
Socioeconomic status		
Lower	29	48.33
Middle	27	45
Upper	4	6.67
Marital status		
Unmarried	29	48.34
Married	26	43.33
Other(separated/divorced/widowed)	5	8.33

This table presents the sociodemographic characteristics of the participants. The mean age of participants was 37.23 ± 14.95 years. The majority of participants in our study fell within the 21-30 years age group (28.33%), followed by the 31-40 years group (25%). Participants above 60 years were the least represented (8.33%). There was a notable gender imbalance, with females comprising the majority (76.66%) compared to males (23.33%). A significant proportion of participants had primary education (56.66%), while only 10% were graduates. More participants hailed from rural areas (58.33%) than urban areas (41.66%). Nearly half of the participants belonged to the lower socioeconomic class (SES) (48.33%), with a minority in the upper class (6.67%). Almost half of the participants were unmarried (48.33%), while a smaller percentage were married (43.33%). A few participants were either divorced, separated, or widowed (8.33%).

Table 2: Distribution of participants according to Family history (history of schizophrenia/ATPD/Bipolar affective disorder) and past history of psychiatric illness (ATPD) (N=60):

Family history	**Number of patients (N=60)**	**Percentage (%)**
Absent	47	78.33
Present	13	21.67
Past history		
Absent	50	83.33
Present	10	16.67

This table shows that majority of participants (78.33%) lack family history of psychiatric illnesses**.** Also, most participants (83.33%) had no past history of psychiatric illnesses.

Table 3: Distribution of participants according to Chief complaints (N=60):

Chief Complaints	Number of patients (N=60) *	Percentage (%)
Impaired sleep	47	78.33
Hearing voices not heard by others	28	46.67
Decreased interactions	25	41.67
Irritability	25	41.67
Suspiciousness that someone wants to harm him	23	38.33
Impairment of daily activities	16	26.67
Suspiciousness that people are talking ill about him	13	21.67
Low mood	12	20.00
Odd behaviour	12	20.00
Decreased appetite	11	18.33
Increased talkativeness	10	16.67
Fearfulness	9	15.00
Poor self-Care	8	13.33
Irrelevant talks	7	11.67
Increased self esteem	6	10.00
Refusal to eat	5	8.33
Maintaining abnormal posture for long	4	6.67
Anxiousness	4	6.67
Suspiciousness that spouse is having an extra marital affair	3	5.00
Death wishes	2	3.33
Excessive worries regarding somatic symptoms	2	3.33
Assaultive behaviour	2	3.33
Tingling sensation over legs	1	1.67
Repetitive action	1	1.67

* All observations are not mutually exclusive

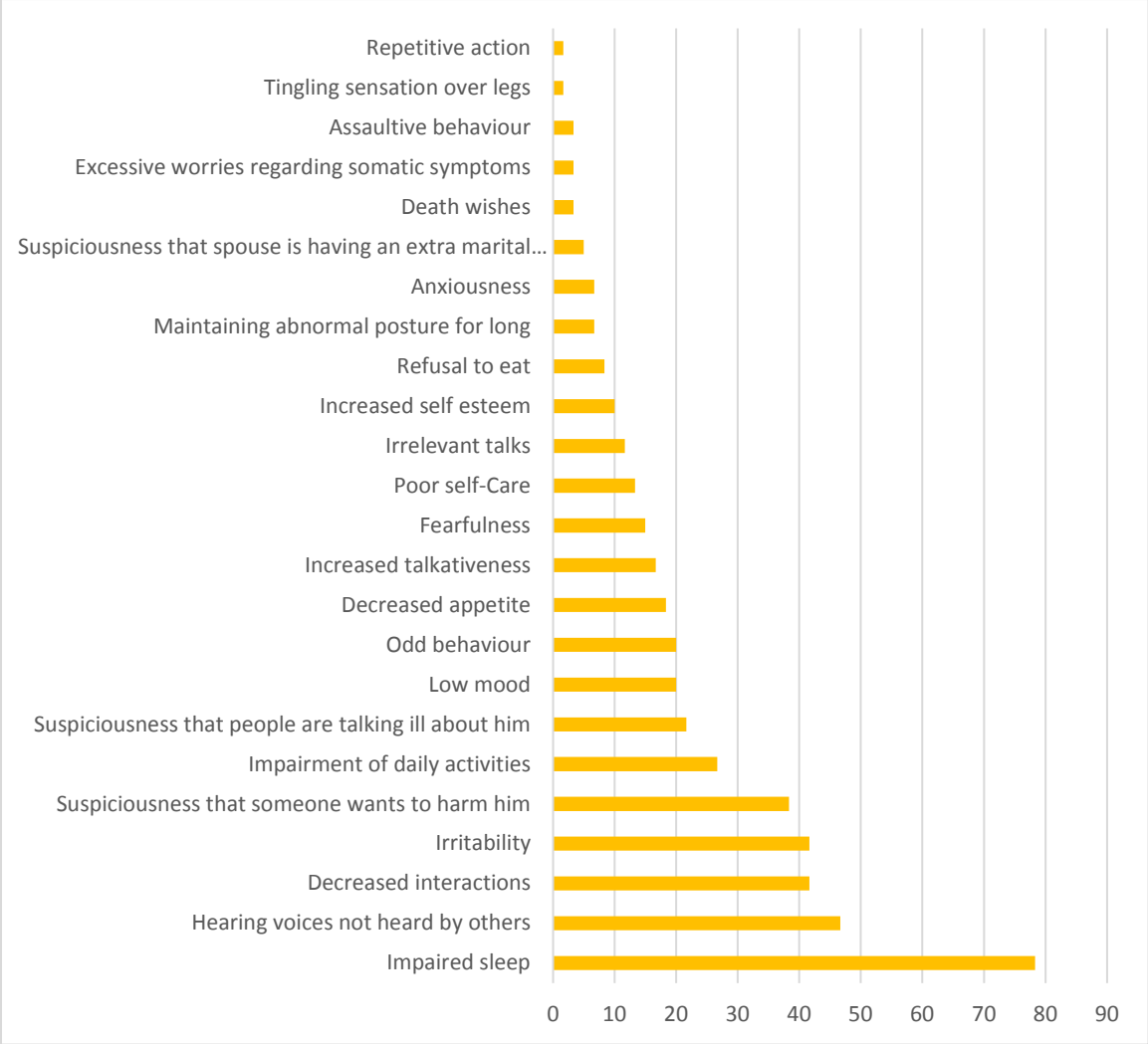


Figure 3: Distribution of participants according to Chief complaints:

This bar chart represents various chief complaints reported by participants, Sleep disturbances were the most frequently reported issue. (78.33%) followed by muttering to self, irritability, decreased interactions and suspiciousness.

Table 4: Distribution of participants according to Global assessment of functioning (GAF) scores (N=60):

GAF	Number of patients (N=60)	Percentage (%)
1-10	12	20%
11-20	26	43.34%
21-30	20	33.33%
31-40	2	3.33%

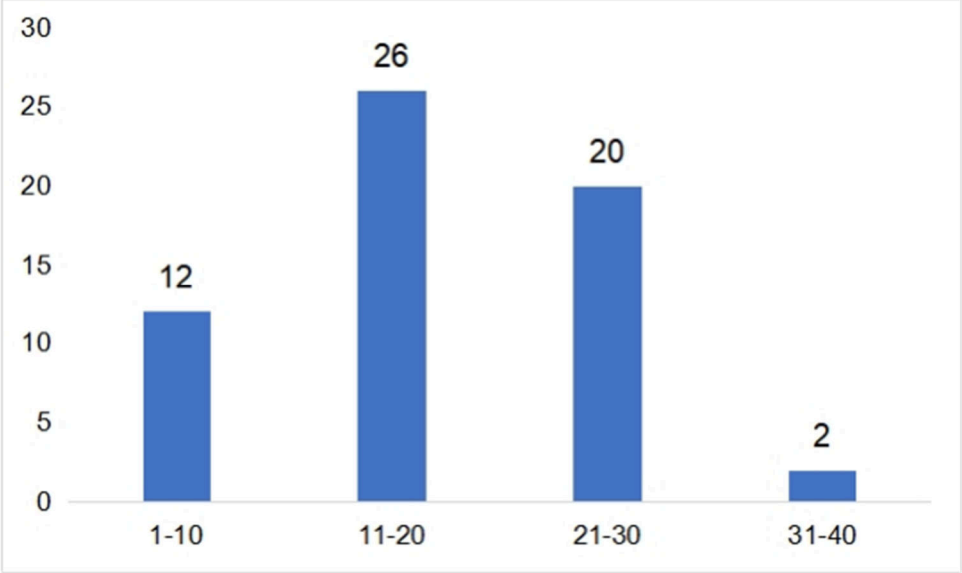


Figure 4: Distribution of participants according to Global assessment of functioning (GAF) scores

This bar chart illustrates the distribution of GAF scores, most participants were in the range of 11 to 20, comprising the majority (43.34%).

Table 5: Distribution of participants according to Catatonic symptoms (N=60, n=9):

Catatonic symptoms (n=9)		**Number of patients (N=60)**	**Percentage (%)**
Absent		51	85%
Present		9	15%
	Mutism	8	88.88%
	Rigidity	6	66.66%
	Withdrawal	6	66.66%
	Posturing	6	66.66%
	Staring	4	44.44%
	Negativism	3	33.33%
	Mannerisms	2	22.22%
	Ambitendency	2	22.22%
	Excitement	1	11.11%
	Stupor	1	11.11%
	Waxy flexibility	1	11.11%
	Automatic obedience	1	11.11%
	Mitgehen	1	11.11%
	Autonomic abnormality	1	11.11%

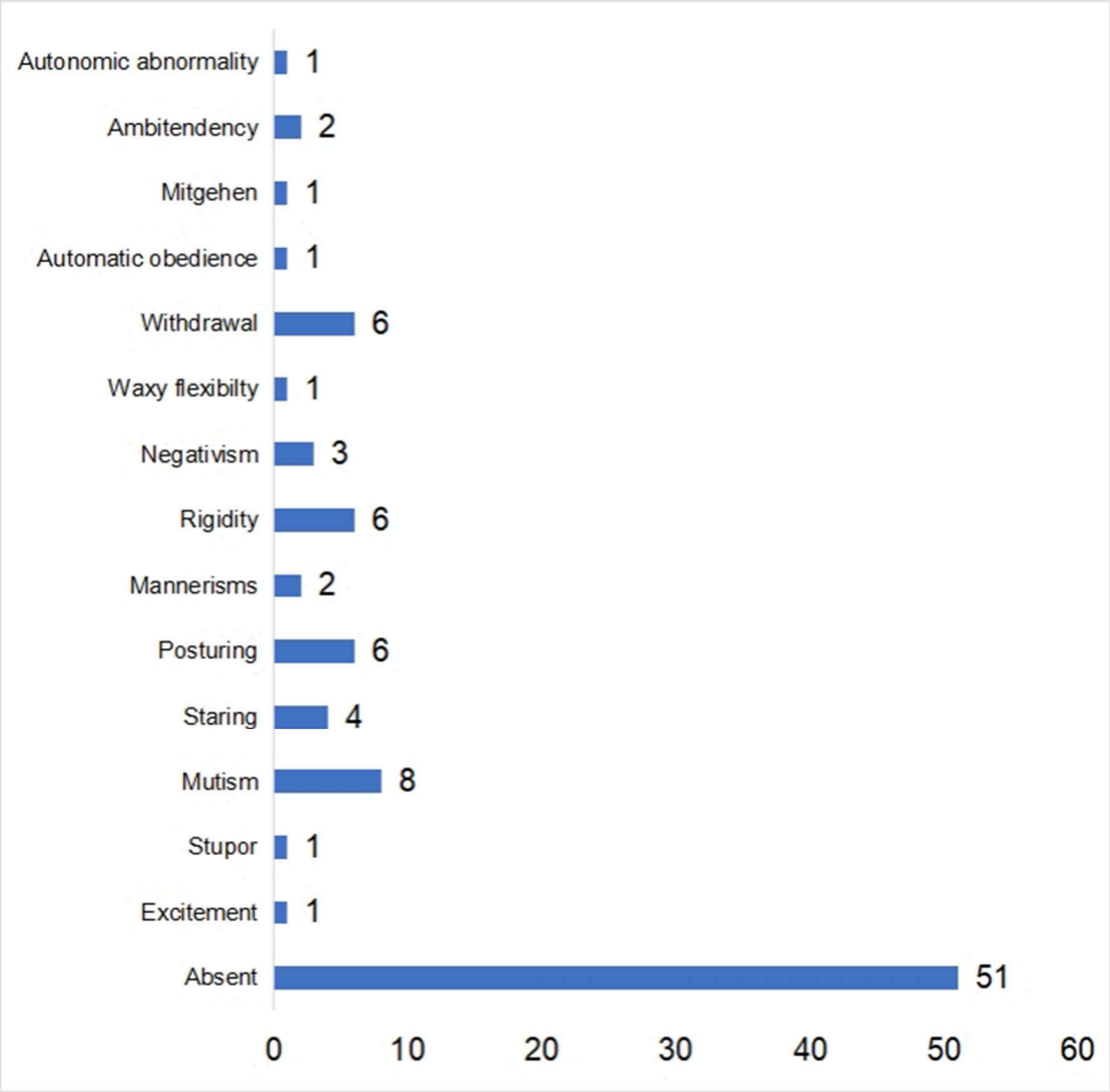


Figure 5: Distribution of participants according to Catatonic symptoms:

This bar chart indicates that a significant majority of participants (85%) did not exhibit catatonic symptoms. 15% had catatonic symptoms among which mutism (88.88%) was most common followed by withdrawal posturing and rigidity.

Table 6: Distribution of participants according to level of Psycho motor activity (N=60):

Psycho motor activity	**Number of patients (N=60)**	**Percentage (%)**
Normal	27	45%
Increase	17	28.33%
Decrease	16	26.67%

In this pie chart most participants (45%) had normal level of psychomotor activity. However, a majority of 55% had disturbances in PMA. Either increased or decreased which were almost equal in occurrence.

Table 7: Distribution of participants according to impairment in Higher Mental Functions (N=60):

Attention	**Number of patients (N=60)**	**Percentage (%)**
Arousable	22	36.67%
Unarousable	38	63.33%
Concentration		
Sustained	23	38.33%
Not Sustained	37	61.67%
Orientations		
Orientation: oriented to time, place, and person	56	93.33%
Disoriented to time	3	5%
Disoriented to place	1	1.67%
Immediate Memory		
Intact	44	73.33%
Impaired	16	26.67%
Thinking		
Concrete	56	93.33
Abstract	4	6.67

Illustrates the distribution of participants based on higher mental functions: 63.33% of participants exhibited unarousable attention. 38.33% had no issues with concentration. The majority (73.33%) were oriented to time, place, and person, with intact immediate memory. Recent and remote memory was assessed. However, was not added as it was found to be intact in all the participants. The majority of participants (93.33%) exhibited concrete thinking.

Table 8: Distribution of participants according to Disorders of Thought (N=60):

Thought	Number of patients (N=60) *	Percentage (%)
Disorders of content		
Delusion of persecution	30	50.00
Delusion of reference	15	25.00
Ideas of helplessness	10	16.67
Ideas of grandeur	7	11.67
Preoccupation with stressor	7	11.67
Ideas of reference	6	10.00
Suicidal ideations	5	8.33
Preoccupation with somatic symptoms	5	8.33
Delusion of infidelity	4	6.67
Ideas of worthlessness	4	6.67
Ruminations	3	5.00
Bizarre delusions	3	5.00
Guilt	2	3.33
Delusional perception	1	1.67
Disorders of disorders of possession		
Thought broadcast	2	3.33
Disorders of form		
Loosening of association	1	1.67
Poverty of speech	1	1.67
Disorders of stream		
Flight of ideas	2	3.33
Prolixity	1	1.67

*All observations are not mutually exclusive

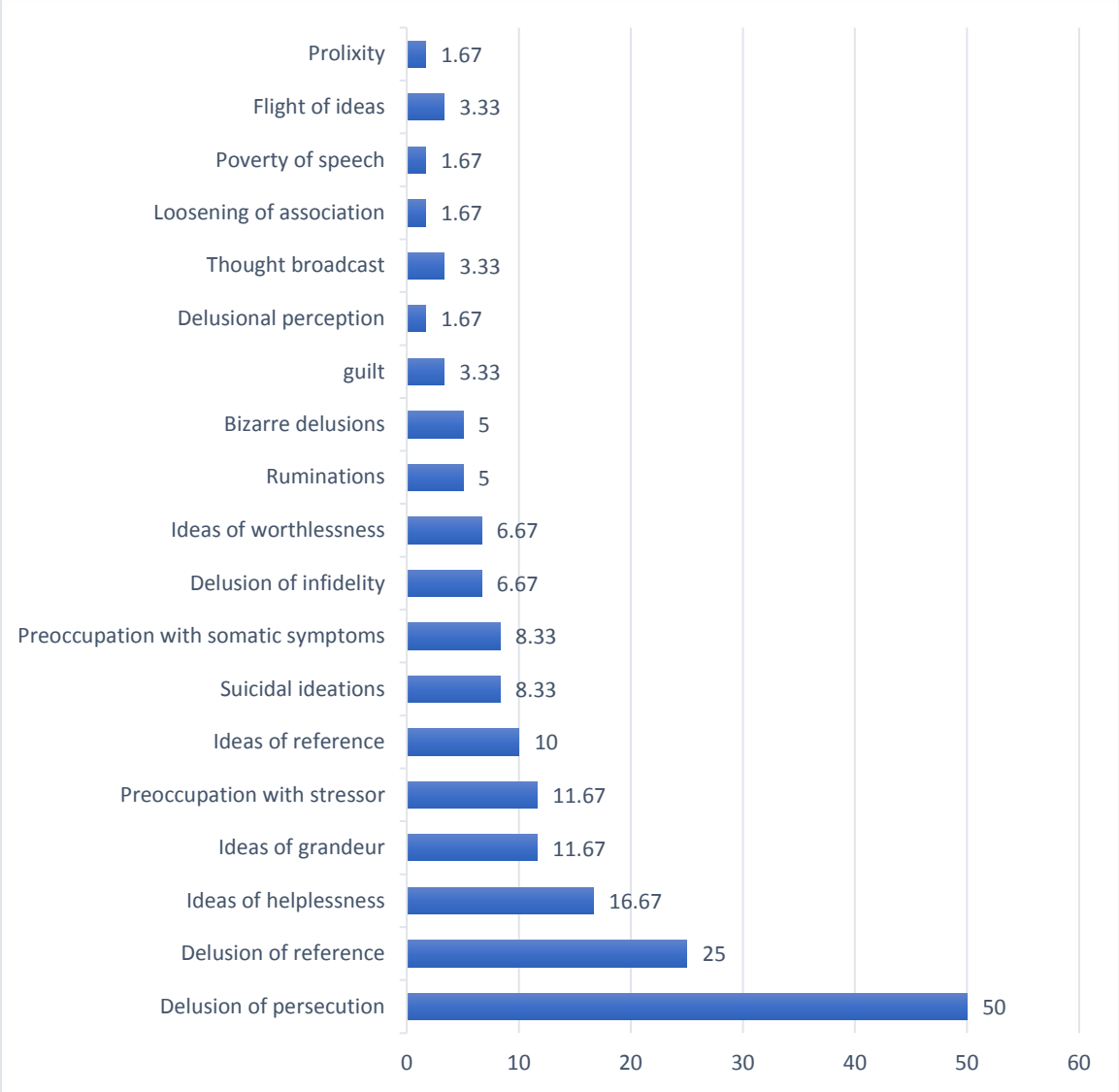


Figure 6: Distribution of participants according to Disorders of Thought

This bar chart demonstrates that most participants showed abnormalities in their thought processes. This high prevalence suggests that thought disturbances are a common feature among the participants. Majority had delusions among which persecution (50%) most present in major of the population followed by referential delusions (25%).

Table 9: Distribution of participants according to Hallucinatory experiences (N=60, n=54):

Hallucinations	**Number of patients (N=60) ***	**Percentage (%)**
Present(n)	54	90
Absent	6	10
2nd person auditory hallucinations	21	38.89
3rd person auditory hallucinations	10	18.52
Mood congruent auditory hallucinations	6	11.11
Running commentary 3rd person auditory hallucinations	4	7.41
Elementary hallucinations	4	7.41
Tactile hallucinations	2	3.70
Commanding 2nd person auditory hallucinations	2	3.70
Functional hallucinations	1	1.85
Reflex hallucination	1	1.85
Pseudohallucinations	1	1.85
Extracampine hallucination	1	1.85

* All observations are not mutually exclusive

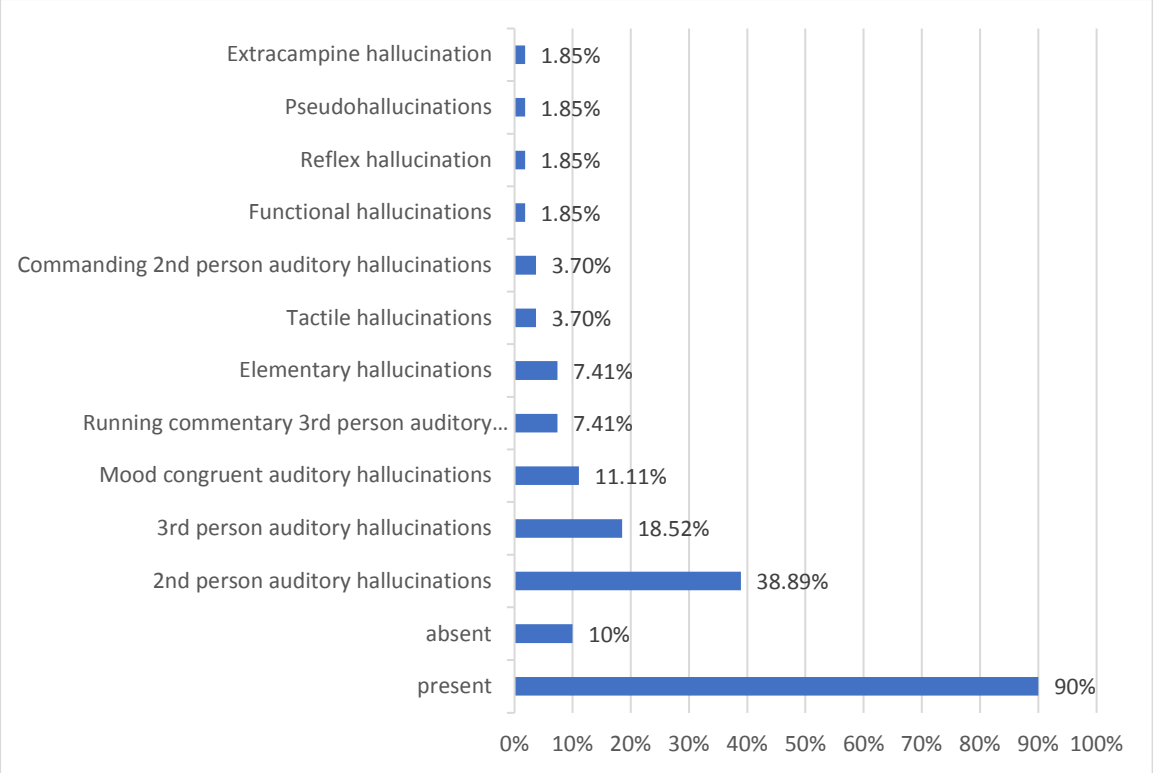


Figure 7: Distribution of participants according to Hallucinatory experiences

This figure illustrates that out of the 60 participants assessed, 6 did not exhibit perceptual disturbances. Among those who did, auditory hallucinations: second and third person were the most common.

Table 10: Distribution of participants according to Affect disturbances (N=60):

Affect	**Number of patients (N=60)**	**Percentage (%)**
Anxious	21	35
Irritable	13	21.6
Depressed	12	20
Euthymic	6	10
Elevated	3	5
Constricted	3	5
Blunt	1	1.6
Dysphoric	1	1.6

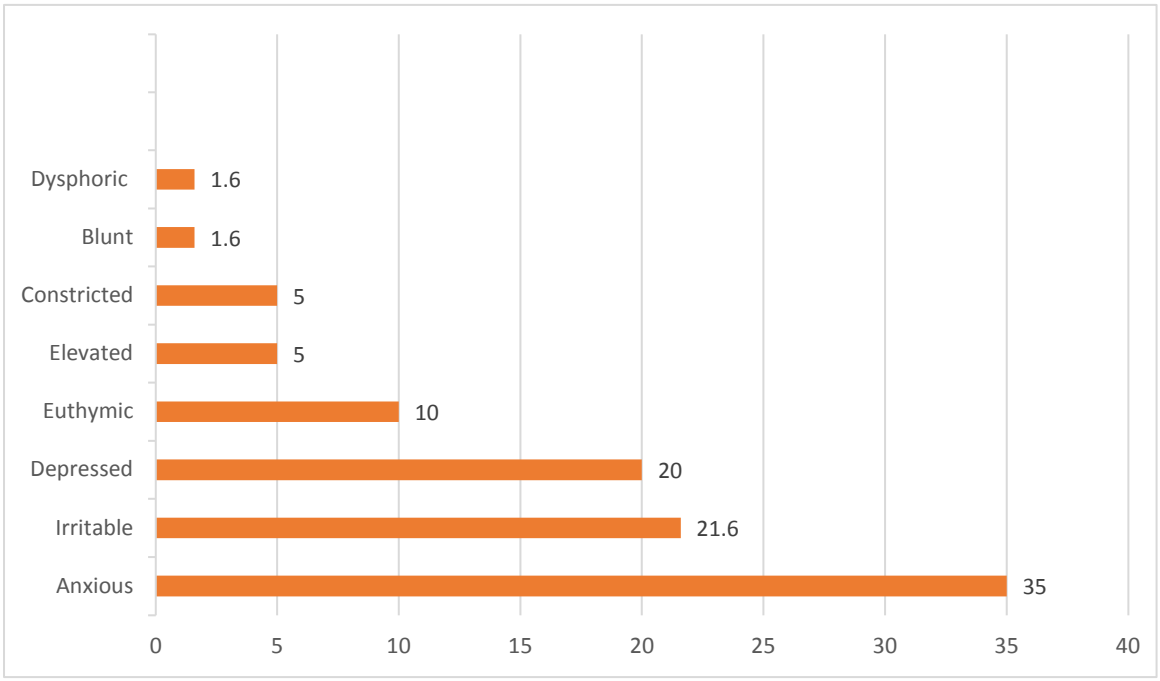


Figure 8: Distribution of participants according to Affective disturbances

This bar chart reveals that 90% of participants had affective disturbances. Majority having anxious (35%) followed by irritable affect (21.60%)

Table 11: Distribution of participants according to Insight (N=60):

Insight	Number of patients (N=60)	Percentage (%)
Grade I	48	80%
Grade II	7	11.67%
Grade III	3	5%
Grade IV	0	0
Grade V	0	0
Not assessed	2	3.33%

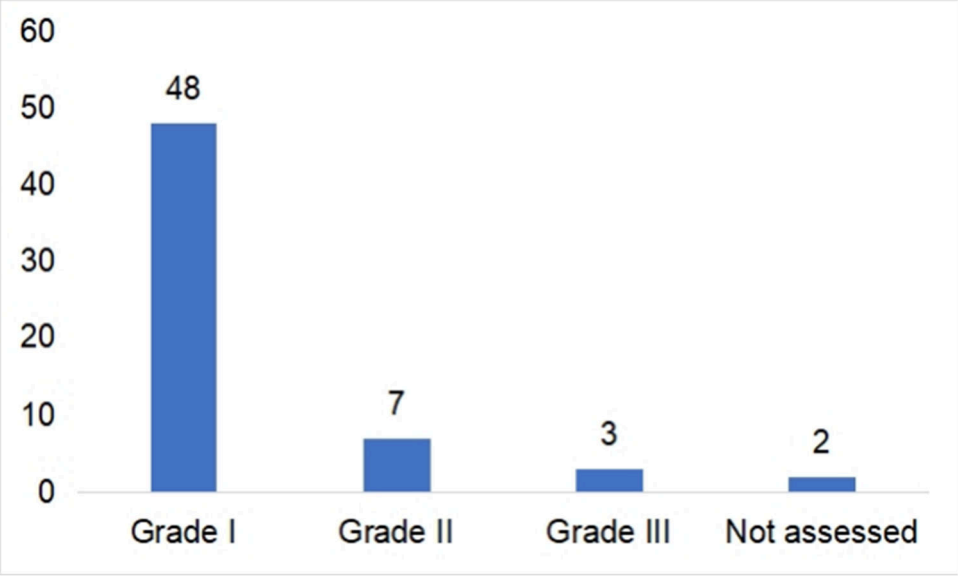


Figure 9: Distribution of participants according to Insight

Bar graph shows that major lacked insight (80%)

Table 12: Distribution of participants according to Judgement (N=60):

Judgement	Number of patients (N=60)	Percentage (%)
Intact	0	-
Impaired	58	96.67%
Not assessed	2	3.33%

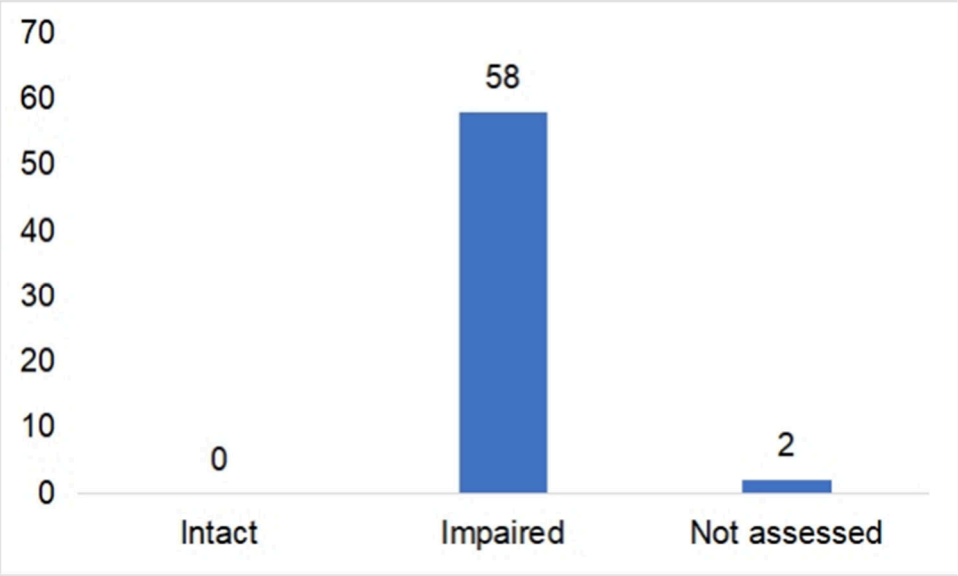


Figure 10: Distribution of participants according to Judgement

This bar diagram reveals that mostly all participants had impairment in judgement (96.67%)

Table 13: Distribution of participants according to diagnostic sub-types based on 1CD-10 classification (N=60):

Diagnosis	**Number of patients (N=60)**	**Percentage (%)**
Acute polymorphic psychotic disorder, without symptoms of schizophrenia	17	28.33%
Other acute and transient psychotic disorders	13	21.67%
Acute polymorphic psychotic disorder with symptoms of schizophrenia	12	20%
Acute and transient psychotic disorder, unspecified	8	13.33
Acute schizophrenia like psychotic disorder	7	11.67%
Other acute predominantly delusional psychotic disorder	3	5%

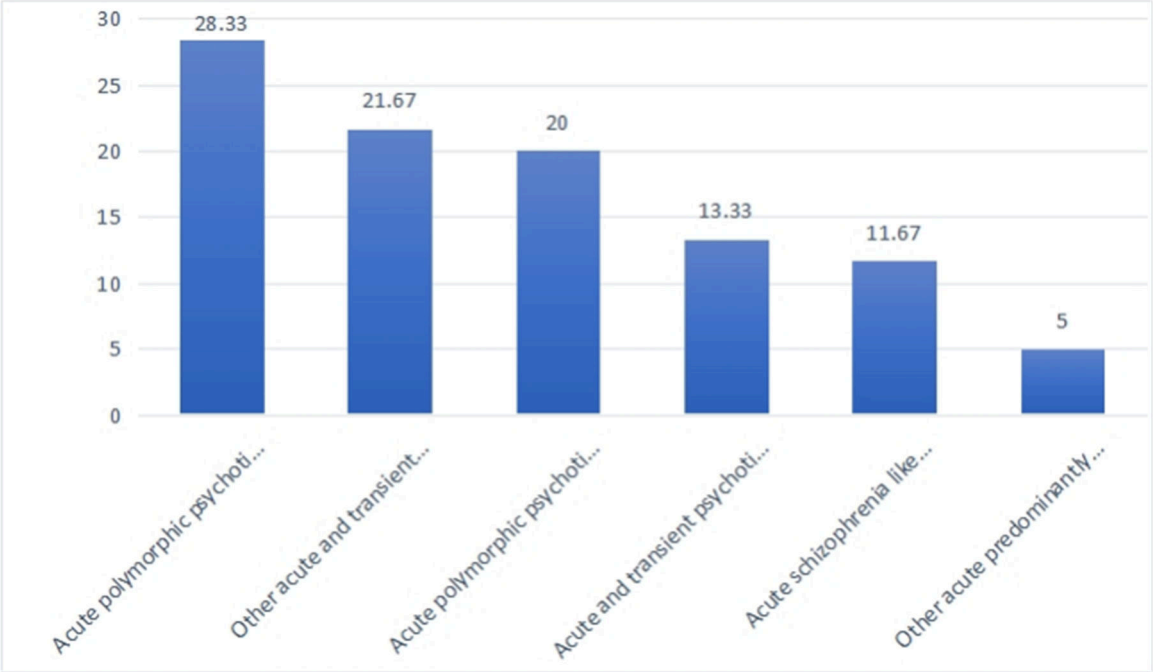


Figure 11: Distribution of participants according to diagnostic sub-types based on 1CD-10 classification

This bar chart shows the distribution of different psychotic disorders among the participants, with the highest percentage (28.33%) attributed to acute polymorphic psychotic disorder without symptoms of schizophrenia.

Table 14: Distribution of participants according to BPRS (N=60):

Symptoms	**Number of patients (N=60) ***	**Percentage (%)**
Suspiciousness	38	63.33
Hallucinations	36	60
Emotional Withdrawal	25	41.66
Distractibility	25	41.66
Anxiety	22	36.66
Uncooperative	22	36.66
Tension	19	31.66
Self-neglect	18	30
Motor retardation	17	28.33
Hostility	17	28.33
Motor hyperactivity	17	28.33
Bizarre behaviour	16	26.66
Depression	13	21.66
Mannerism and posturing	13	21.66
Unusual thought content	11	18.33
Excitement	9	15
Grandiosity	8	13.33
Conceptual Disorganization	6	10
Suicidality	5	8.33
Somatic concerns	5	8.33
Blunt affect	4	6.66
Elevated mood	4	6.66
Disorientation	3	5
Guilt	3	5

*All observations are not mutually exclusive

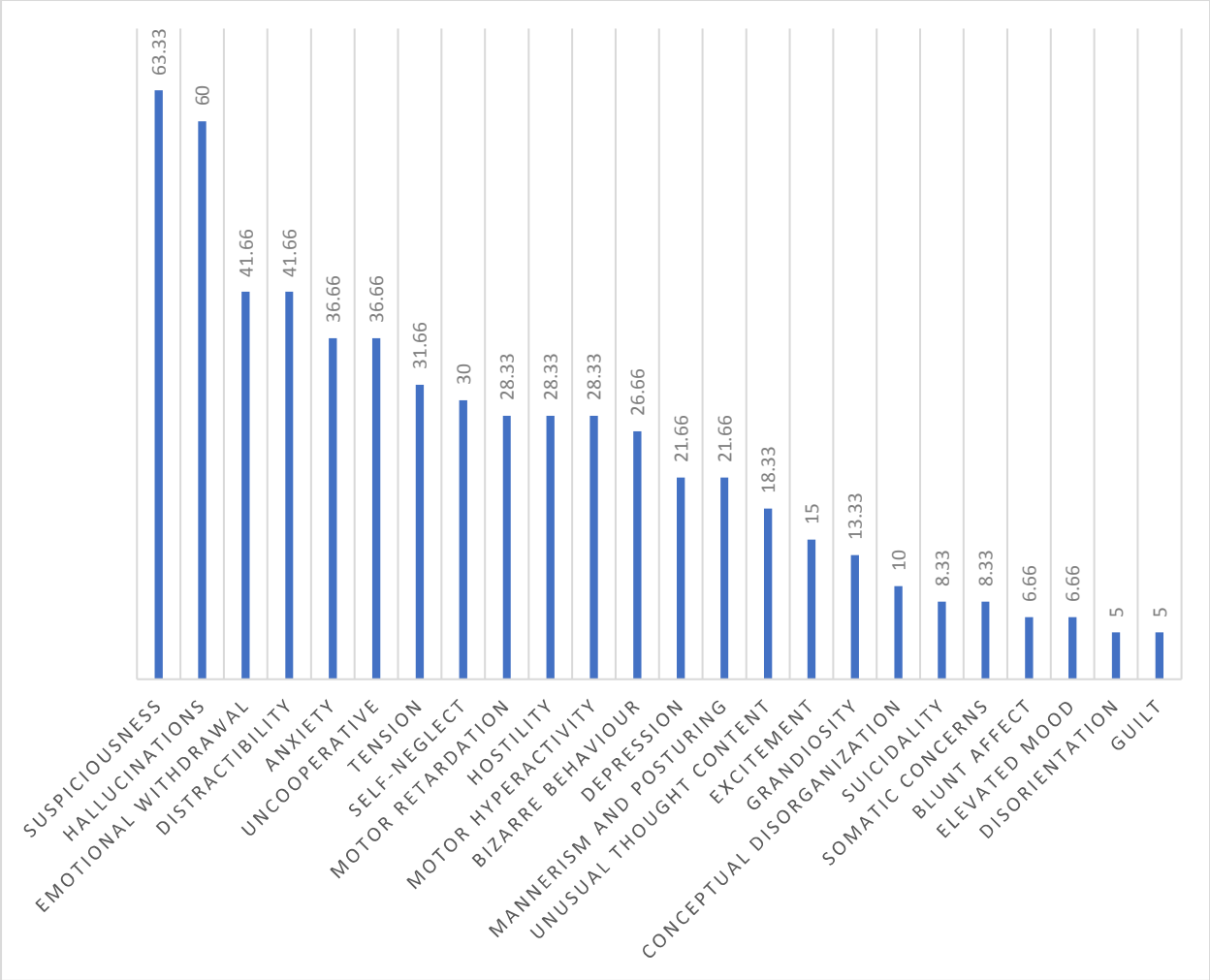


Figure 12: Distribution of participants according to BPRS:

The table presents the prevalence of various symptoms among 60 patients diagnosed with Acute and Transient Psychotic Disorder (ATPD). The most common symptom is suspiciousness, observed in 38 patients, accounting for 63.33% of the sample. Hallucinations are also prevalent, affecting 36 patients or 60%. Emotional withdrawal and distractibility are each seen in 25 patients, representing 41.66%. Anxiety and uncooperativeness are reported in 22 patients, making up 36.66% of the group. Tension is noted in 19 patients (31.66%), while self-neglect is observed in 18 patients (30%). Motor retardation, hostility, and motor hyperactivity each affect 17 patients, corresponding to 28.33%. Bizarre behaviour is present in 16 patients (26.66%), and depression, as well as mannerism and posturing, are noted in 13 patients (21.66%). Unusual thought content is seen in 11 patients (18.33%). Excitement affects 9 patients (15%), and grandiosity is observed in 8 patients (13.33%). Less common symptoms include conceptual disorganization (6 patients, 10%), suicidality and somatic concerns (each

in 5 patients, 8.33%), blunt affect and elevated mood (each in 4 patients, 6.66%), and disorientation and guilt (each in 3 patients, 5%). These observations highlight the diverse and complex symptomatology of ATPD.

Table 15: Distribution of participants according to BPRS score and diagnostic subtypes:

Diagnostic subtypes	Number of patients (N=60)	Mean score ± Standard Deviations
Acute polymorphic psychotic disorder, without symptoms of schizophrenia	17	44.26 ± 6.773
Other acute and transient psychotic disorders	13	47.33 ± 6.99
Acute polymorphic psychotic disorder with symptoms of schizophrenia	12	43.97 ± 8.60
Acute and transient psychotic disorder, unspecified	8	45.49 ± 8.77
Acute schizophrenia like psychotic disorder	7	41.97 ± 7.4
Other acute predominantly delusional psychotic disorder	3	36.45 ± 7.84

The largest subgroup identified was acute polymorphic psychotic disorder without symptoms of schizophrenia, comprising 17 patients with a mean score of 44.26 ± 6.773 on the assessment scale. The next significant groups were other acute and transient psychotic disorders (13 patients, mean score 47.33 ± 6.99) and acute polymorphic psychotic disorder with symptoms of schizophrenia (12 patients, mean score 43.97 ± 8.60). Smaller subgroups included acute and transient psychotic disorder, unspecified (8 patients, mean score 45.49 ± 8.77), acute schizophrenia-like psychotic disorder (7 patients, mean score 41.97 ± 7.4), and other acute predominantly delusional psychotic disorder (3 patients, mean score 36.45 ± 7.84).

DISCUSSION

Our study was an observational investigation aimed at assessing the clinical features of acute and transient psychotic disorders within 48 hours of contact with healthcare services in both inpatient and outpatient settings. We also aimed to classify the diagnostic subtypes of ATPD. Unlike affective psychosis or schizophrenia, ATPD is characterized by rapid symptom onset and a varied clinical presentation. The disorder typically follows a benign course, and existing literature primarily originates from countries like India, with previous studies focusing on symptomatology and phenomenology in North India or Western nations. Our study specifically aimed to explore the phenomenology of ATPD within a general hospital setting in South India. Conducted at a tertiary care hospital, the study involved 60 patients diagnosed with the disorder across the psychiatry outpatient and inpatient department

(1) Socio-demographic variables of the participants (Refer to table 1):

The average age of the patients was 37.23 ± 14.95 years, with the majority of participants belonging to the 21-30 years age group. Another study reported a mean age of 32.45 ± 11.45 years, with most participants falling within the 15-25 years age range[9]. In another study done in 2014 in north India, 185 sample was taken among which most of the participants belonged to an age group of 20 to 39 years[56]. These findings were similar to ours. However, in other study done by Okasha. Et al.[57] in an Egyptian sample, In an Egyptian study involving 50 participants, the author reported a mean age of 26.65 ± 9.75 years. This differs from our study's findings, likely due to variations in the inclusion criteria used by the researcher. Their criteria included participants without a history of mental illness, those with symptom onset up to 3 months before seeking healthcare, and individuals meeting criteria for hypomania or major depressive episodes, which were not included in our study.

A significant gender disparity was seen in our study, with female patient constituting 76.67% of the population studied. Similarly, in another study done by Sajith et al. [43] 73.3% of the participants were females. However, some other studies showed equal distribution of participants based on sex[9,58]. This might be due to the difference in the stressors experienced by men and women. Women are often more vulnerable to social and environmental stressors, which can trigger acute psychotic episodes. For instance, stress related to familial and marital issues, social expectations, and economic pressures are known to affect women disproportionately[59]. Additionally, hormonal differences might play a role[59]. Another contributing factor could be the higher tendency for women to seek help for mental health issues compared to men. This could lead to a higher detection rate of ATPD in women in clinical settings, skewing the observed prevalence in favour of women[60]

Majority of the patients (56.66%) attained primary level of education in our sample, 15% were illiterate, 8.33% went to middle school and a minority 10% were graduates. Similarly, In a study done by Singh et al.[9] in Shimla, 2% were illiterate, 6.67% went to primary school, 18.67% middle school and 7.33 % were graduates. However, in another study that was done in Spain in 2018, Lopez Diaz et al.[61] 27% of the patients had primary level education rest 73% had secondary and above. This difference in findings might probably due to difference in education policies of different nations.

Most participants were from rural domicile (58.33%) in our study. Our findings were similar to a study done in Shimla in which 96.67% participants belonged to a rural area[9]. In another study done in Pondicherry by Sajith et al.[43] 80% of the population was from a rural background as well. these findings are in accordance with are study probably because most of these studies that are carried in general hospitals reel in more patients from rural areas as they situated in semi urban or rural areas.

Socioeconomic status of most participants in our study was lower 48.33%, followed by middle 45% and least patients belonged to upper SES i.e. 6.67%. Similarly, in Sajith et al.[43] 68% participants belonged to upper SES followed by middle and least participants belonged to lower SES. These findings were consistent with ours.

When examining the marital status of participants in our sample, 43.33% were married, while 48.34% were unmarried, and 8.33% were either separated or widowed. This distribution contrasts with the findings of Mishra et al.[10] (2023) in India, where 58.4% of the patients were married. Several factors, such as geographic location and cultural context, may account for this discrepancy. Marital status is a crucial sociodemographic factor that can influence the onset, progression, and outcome of psychiatric disorders, including acute psychosis. According to an article by Janhavi et al.[62], mental disorders are associated with lower perceived social support, and being married may significantly impact this relationship.

(2) Family and Past history of psychiatric illness participants (Refer to table 2)

In our study, few 21.67% had positive family history of either bipolar disorder, schizophrenia or acute psychosis. Similarly in a study done by Mehta. et al[2] 23 % participants had positive family history of psychiatric disorders, which was close to our findings

Some participants (16.66%) showed recurrence of ATPD. Earlier studies, did report the recurrence of ATPD from 10%[63] to 11.7%[20] and Rozario et al.[64] another reported a recurrence rate of 35% after 5 years. This may be due incomplete treatment or non-adherence to treatment [65], genetic predispositions [66], stress or lack of social support [67] to name a few.

(3) Presenting complaints of the participants (Refer to table no. 3):

Most of the patients came with varied presenting complaints among which sleep disturbances were most common (78.33%), followed by hearing of voices (46.67%), reduced interactions(41.67%), irritability(41.67%), paranoia(38.33%), bizarre behaviour(20%), decreased appetite (18.33%) ,increased talkativeness(16.67%),fearfulness(15%), poor self-care (13.33%), rest high self-esteem, abnormal posture, anxiousness, death wishes, somatic complaints, repetitive behaviour were found to be present to a lesser degree. Similarly, in a study done by Okasha et al.[57] worrying (48%) followed by delayed sleep (42%), followed by depressed mood (36%), irritability (30%), social withdrawal, decreased concentration, anxiety, hysterical behaviour, paranoia, suspiciousness (26%), bizarre behaviour (22%) were the presenting complaints that the participants came with to the hospital set up. While, In other done by Chavan et al.[53] impaired sleep and deceased appetite were seen to be most common and according to McCabe et al. [25] depressive and anxiety symptoms were found to be the most which was different from our findings. This difference may be due to different socio-cultural backgrounds[19,57] of the study participants and difference in health care access and utilization[68].

(4) GAF assessment at the time of admission in the participants (Refer to Table 4):

In our study, all participants had a GAF score below 40, with the majority falling between 11 and 20. This indicates a severe level of impairment in social, occupational, and psychological functioning. Many participants demonstrated significant symptoms, such as the considerable influence of delusions or hallucinations, or serious impairments in communication. These findings contrast notably with other studies. For instance, Jøgersen et al.[59] reported that patients diagnosed with Acute and Transient Psychotic Disorder (ATPD) generally had GAF scores below 70, and most did not require hospitalization. Another study involving 85 patients found a baseline mean GAF score of 30.5[69], suggesting a higher overall level of functioning compared

to our participants. This may be due to delay in seeking healthcare services leading to more impairment and also due to higher stress in rural areas due to lower SES and higher level of poverty in these regions.

(5) Catatonic symptoms in participants (Refer to table 5):

Catatonia was present in 15% of our patients, among which 88.88% had mutism, 66.66% rigidity followed by withdrawal, posturing and staring. Whereas, negativism, mannerism, ambitendency, excitement, stupor, waxy flexibility, automatic obedience, mitgehen, autonomic abnormality was present in few of the patients. Similarly, a study conducted by Ranjan et al.[58] carried out in Nepal, 30 participants diagnosed with ATPD were studied among which 10% patients had catatonic symptoms, however which all specific symptoms were present was not enumerated by the study. In another study, done by Subramaniyam et al.[70] In Bangalore, India, a study involving 300 participants found that 32 individuals (10.7%) were diagnosed with brief psychotic disorder, with 13.6% of them exhibiting catatonic symptoms. In these patients staring (52.5%), withdrawal (45%), mutism (40%) followed posturing/catalepsy (35%), excitement (25%), stupor/immobility (22.5%) and rigidity (22.1%) were found to be the most common. These findings in the frequency of presentation of catatonic symptoms is slightly different from our findings. This may be due to differences in same size of different studies.

(6) Level of psychomotor activity in participants (Refer to table 6):

When the data was analysed in our study, we found that 55% of our study population had disturbances in PMA level, among these 28.33% had increased PMA while 26.67% showed decreased PMA. Other studies[71,72], such as one conducted by Marneros A. et al.[72] in Germany, 42 Acute psychosis patients were evaluated, among these psychomotor disturbances were

found in 85.7% of the population i.e. more patients had psychomotor disturbances. These findings were supported by other studies as well.

(7) Impairment in Higher mental function distribution in participants (Refer to table 7):

In our study populations, higher mental functions were intact in most of the participants, attention and concentration was unarousable (63.33%) and not sustained (61.67%), respectively in most of the patients. in the study done by Singh et al.[9] poor attention and concentration was found in 98% of the patients. In another study[73] 73.5 % population had impairment. These findings align with our findings.

Our study found that 93.33% of participants with acute psychosis were oriented to time, place, and person, indicating that most individuals with this condition retain their orientation. This high percentage of intact orientation aligns with the findings of Singh et al.[74], where only 1.33% of participants exhibited disorientation. Such consistency suggests that despite the acute nature of psychosis, cognitive functions related to orientation often remain unaffected.

Immediate memory done according to digit span test was found impaired in 26.67% participants. In a study done in Congo, by Ngoma M. et al.[75] disturbances in memory was found in patients suffering from psychotic disorders.

In our study, 93.33% of participants demonstrated concrete thinking, indicating that abstract thinking is notably impaired in the majority of individuals with acute psychosis. This finding contrasts with the results of Singh et al.,[9] where 73% of participants had difficulty with abstract thinking. The discrepancy may be attributed to differences in study populations, assessment methods, use of antipsychotics for sedation or diagnostic criteria.

Further, Kumar et al.[13] found that over 90% of their participants exhibited impairment in abstract thinking, which aligns more closely with our findings. This consistency suggests that difficulty in abstract thinking is a common feature among patients with acute psychosis. Variations in the severity of psychosis and the specific subtypes of psychotic disorders among study populations might account for the differences observed across studies.

(8) Disorder of thought in participants (Refer to table 8):

Our study highlights various thought disorders among participants with acute psychosis. The most common thought disorder was the delusion of persecution, seen in 50% of our participants. This aligns with the findings of Johanna et al. (2021)[73],a study done in 2021 in Germany where 597 patients were assessed in a general hospital set up, in their study 63% of patients exhibited persecutory delusions. Comparative data from Chavan et al.[53] in Chandīgarh also highlighted high rates of delusion of persecution (68%) and other delusional themes. Similarly, Menon M.S. et. al.[76] in Chennai also reported a significant prevalence of paranoia in 44% of the sample of 75 patients. This consistency suggests that delusions of persecution are a prevalent symptom in acute psychosis across different populations and also indicates consistency across different regions in certain delusional types.

In our study, delusions of reference were present in 25% of participants, comparable to the 19.1% reported by Johanna et al.[73] This is also comparable to a study done in Germany on 42 patients diagnosed with ATPD who had delusion of reference in 78.6% patients[11]This similarity underscores the frequent occurrence of such delusions in individuals with acute psychosis.

In our sample, ideas of grandeur were present in 11.67% of participants. This is slightly lower than the 14.66% reported by Singh et al.,[9] In a study involving 150 patients diagnosed with

ATPD in North India, findings suggest regional or diagnostic variations in the expression of grandiosity. However, these results align with those of Marneros et al.[27], where grandiosity was observed in 19.0% of subjects.

Ideas of helplessness were seen in 16.67% of our participants, which is not directly comparable to the Johanna et al.[73] study as they did not categorize this specific symptom. However, the occurrence of diverse depressive and anxious symptoms in both studies indicates substantial similarities in the emotional and cognitive disruptions linked with acute psychosis. Preoccupation with stressors was noted in 11.67% of our participants, while somatic symptoms were observed in 8.33%. These figures are slightly lower compared to the 20% preoccupation and 23.33% somatic concerns reported by Singh et al.[9] Such differences might reflect variations in stressors or cultural attitudes towards somatic complaints.

Suicidal ideations were noted in 8.33% of our participants, compared to the 23.3% reported by Johanna et al.[73] This significant discrepancy may result from differences in the severity of the studied populations or varying clinical environments.

Bizarre delusions were seen in 5% of our participants, which is considerably lower than the 56.67% reported by Singh et al.[9] This variation could be due to differences in diagnostic criteria or cultural perceptions of what constitutes a bizarre delusion. In our sample delusion of infidelity was present in 6.67% of the patients. In Chavan et al.[53] study done in Chandigarh, India in 22 patients 22% patients had other delusions such as morbid jealousy.

Our study found that 3.33% of participants experienced guilt, whereas Singh et al.[9] reported an 11.33% prevalence of guilt. In another it was 14.3%[11,72]. This lower percentage in our study may reflect differences in how guilt is perceived and reported in different cultures. Ruminations

was present in 5% of our population. However, it was present in 11.9% patients in a study as reported by Marneros et al.[11] and 27% in Chavan et al.[53].

Thought disorders related to the possession of thought, such as thought broadcasting, were present in 3.33% of our participants. Johanna et al.[73] did not specifically report on thought broadcasting but did mention the presence of it , making direct comparisons challenging.

Formal thought disorders, such as loosening of association and poverty of speech, were rare in our study, each affecting only 1.67% of participants. Flight of ideas and prolixity was present in 3.33% and 1.67% of our population, respectively. In contrast, Johanna et al.[73] reported a much higher prevalence of formal thought disorders (84.3%). This discrepancy suggests differences in diagnostic practices or the populations studied.

Overall, our findings highlight the variability in the presentation of thought disorders in acute psychosis across different regions and studies. These differences underscore the importance of considering cultural, environmental, and diagnostic factors when assessing and treating individuals with acute psychosis. Further research is needed to standardize assessment tools and explore the underlying factors contributing to these variations.

In conclusion, our study contributes to the understanding of thought disorders in acute psychosis, emphasizing both commonalities and variations across different populations. These findings underscore the importance of considering cultural, environmental, and diagnostic factors in evaluating and treating individuals with acute psychosis. Future research efforts should aim to standardize assessment tools and explore underlying factors contributing to these observed variations

(9) Hallucinatory experiences among participants (Refer to table no.9):

Our study explored the presence and types of hallucinations among participants with acute and transient psychotic disorders (ATPD). We observed that 54 participants (90%) experienced hallucinations, while 6 participants (10%) did not. This high prevalence aligns with findings in the literature, which consistently report hallucinations as a common feature in ATPD[10–12,53,72,77].

Specifically, auditory hallucinations were the most frequent type in our study, with 38.89% of participants experiencing 2nd person auditory hallucinations and 18.52% reporting 3rd person auditory hallucinations. This is align with findings by Sandeep Grover et al.[12], who reported auditory hallucinations ranging from 30%[16,42] to 95%[9], with 36% [53] of patients experiencing auditory hallucinations in other studies[12].

Specifically, in kumari et al.[15] 30% 3rd person auditory hallucinations present. Additionally, Marneros et al.[78] highlighted the prominence of auditory hallucinations in ATPD, noting that 47.6% of their participants experienced commanding voices 35.7% had commenting voices and voices in dialogue (23.8%)[79].

In our study, mood-congruent auditory hallucinations were present in 11.11% of participants, with 7.41% experiencing running commentary hallucinations. Elementary hallucinations and tactile hallucinations were each reported by 7.41% and 3.70% of participants, respectively. Commanding 2nd person auditory hallucinations were seen in 3.70% of cases. These findings are consistent with Mishra et al., who found that 34.2% of their participants experienced hallucinations, with 27.6% reporting auditory hallucinations[10]. Our study's rate of bodily hallucinations was 3.7%, which contrasts with Mishra et al.'s higher rate of 10.4% for bodily hallucinations[10].

Additionally, we identified fewer common types of hallucinations in our sample, including functional hallucinations, reflex hallucinations, pseudohallucinations, and extracampine hallucinations, each reported by 1.85% of participants. These rare types of hallucinations were also noted in our study and further illustrate the diverse nature of hallucinations in ATPD.

In terms of specific auditory hallucinations, our data showed that 35.1% of participants experienced commenting auditory hallucinations, a prevalence rate consistent with the broader literature[12,77]. Furthermore, 30% of participants experienced 3rd person auditory hallucinations, which aligns with findings by Marneros et al., who reported 38.1% prevalence of delusional misidentification and hallucinations in their cohort[11].

Overall, our findings underscore the high prevalence and variability of hallucinations in ATPD. The prevalence of auditory hallucinations, especially commanding and commenting voices, underscores their significant role in the psychopathological profile of ATPD. The lack of visual hallucinations in our study contrasts with Marneros et al., who reported visual hallucinations in 16.7% of their participants, highlighting the need for further investigation into the regional and diagnostic differences in hallucination types within ATPD[72].

These observations indicate that hallucinations represent a central feature of ATPD., their manifestation can vary significantly across different studies and populations. This variability underscores the importance of considering individual differences and refining diagnostic criteria to better capture the full spectrum of symptoms in ATPD.

(10) Affect disturbances in participants (Refer to Table no. 10):

Our study identified a spectrum of affective disturbances among participants with acute and transient psychotic disorders (ATPD). The most prevalent affective disturbance observed was

anxiety, affecting 35% of our participants. This observation aligns with findings from multiple studies, including Singh et al.,[9] who reported anxiety in 45.33% of ATPD patients, highlighting its significant presence in acute psychotic episodes.

Similarly, our study found that irritability was present in 21.6% of participants, reflecting its substantial impact on emotional states in ATPD. This aligns with findings by Okasha et al.[57], who reported irritability in 71% of cases, indicating a common affective feature across different populations[80]. This observation aligns with findings from multiple studies.

Depressed mood was observed in 20% of participants in our study, at par with rates reported by Okasha et al.[57] (32.5%) and Kapur et al.[81] (45%), underscoring the manifestation of depressive symptoms across studies and populations[57,81].

Elevated mood were noted in a minority of participants (5% , similar to findings by Kapur et al.[81] (28.3% elevated mood), indicating that manic-like symptoms can also manifest in ATPD albeit less commonly.

Constricted affect was observed in 5% of our participants, consistent with descriptions of blunt or constricted affect reported in various studies, including Castagnini et al.,[82]which noted similar affective polymorphism in ATPD clinical profiles.

Our findings, alongside those from Kapur et al., Singh et al., and Okasha et al., contribute to the understanding that affective disturbances in ATPD encompass a wide range of emotional states, including anxiety, irritability, and occasional depressive or elevated moods. These disturbances are integral to the clinical presentation of ATPD, distinguishing it from other psychotic disorders like schizophrenia, which typically feature more pronounced negative symptoms[82,83].

(11) Insight in participants (Refer to table no. 11):

Based on our findings, the majority of participants exhibited varying degrees of impaired insight. This observation is consistent with the literature on acute psychosis, which frequently reports a lack of insight as a common symptom. Similarly, a study by David et al.[84] found that patients with acute psychosis often have limited awareness of their condition, which can impede their willingness to engage in treatment. Even in the research conducted by Singh et al,[9] impaired insight was found in 100% of the patients. hence, our finding aligns with current literature available.

(12) Judgement in participants (Refer to table 12):

Our study found that a striking 96.67% of participants with acute psychosis exhibited impaired judgment. This high prevalence aligns closely with the findings of Singh et al.,[9]where every participant (100%) displayed judgment impairments. These results underscore the pervasive nature of judgment deficits in acute psychosis, reflecting a critical area of concern for both diagnosis and treatment.

However, contrasting results were observed in a study by Johanna et al.[73], where only 76.3% of participants were found to have impaired judgment. This discrepancy highlights the variability in the presentation of judgment impairments across different studies and populations. Several factors could contribute to this variability, including differences in diagnostic criteria, assessment tools, and the specific characteristics of the study populations.

The high prevalence of impaired judgment in our study and Singh et al.'s[9] study suggests that judgment impairment is a common and significant issue in acute psychosis. Impaired judgment can lead to a range of adverse outcomes, including difficulties in decision-making, increased

risk of harmful behaviours, and challenges in adhering to treatment plans. These impairments are likely influenced by the severity and nature of other psychotic symptoms, such as delusions and hallucinations, which can distort reality and impair cognitive functioning.

On the other hand, the lower prevalence reported by Johanna et al.[73] may reflect differences in the clinical presentation of psychosis or the methodologies used to assess judgment. It is possible that the participants in Johanna et al.'s study had a less severe form of psychosis or that the study employed more stringent criteria for diagnosing impaired judgment. Additionally, cultural and contextual factors might play a role in how judgment is assessed and reported.

(13) Diagnostic-subtypes based on ICD-10 classification and BPRS Score (Refer to table 13 & table 15):

In our study, we assessed the distribution of various diagnostic categories among 60 participants with acute psychosis. The most common diagnosis was acute polymorphic psychotic disorder without symptoms of schizophrenia, observed in 28.33% of the participants with a mean BPRS score of 44.26 ± 6.773. This finding is in contrast to the study by Shaltout and colleagues (2007)[85], where acute schizophrenia-like psychotic disorder was the most prevalent subtype, affecting 35.6% of the patients with score of 41.97 ± 7.44. However, our finding aligns with the distribution reported by Bevin S. et al.,[86] where 20% of cases were diagnosed with acute polymorphic psychosis with symptoms of schizophrenia with BPRS score as 43.12 ± 8.60.

The second most frequent diagnosis in our study was categorized as other acute and transient psychotic disorders, which accounted for 21.67% of the participants with BPRS mean score as 47.3 ± 6.99. This category encompasses a range of psychotic episodes that do not fit neatly into

other specific diagnostic categories. The variability and overlap in symptomatology within this group highlight the complexity of diagnosing acute psychotic disorders.

Acute polymorphic psychotic disorder with symptoms of schizophrenia was diagnosed in 20% of our participants. This percentage is lower than the 37.5% reported by Bevin S. et al.[86]for the same diagnosis (F23.1). The differences in prevalence rates between studies may be attributed to variations in population characteristics, and the clinical settings in which the studies were conducted.

Acute and transient psychotic disorder, unspecified, was noted in 13.33% of our participants. This category is often used when there is insufficient information to make a more specific diagnosis. The use of this category underscores the challenges clinicians face in diagnosing acute psychosis, especially when patients present with rapidly changing or atypical symptoms.

Acute schizophrenia-like psychotic disorder was observed in 11.67% of our participants. This is significantly lower than the 33.9% reported by Bevin S. et al.[86]and the 35.6% reported by Shaltout and colleagues[87]. The lower prevalence in our study may reflect differences in the criteria used to diagnose schizophrenia-like symptoms or variations in the study populations.

In our study, other acute predominantly delusional psychotic disorder affected 5% of the participants with BPRS score as 45.49 ± 8.7 , which aligns closely with the 7.1% prevalence reported by Bevin S. et al.[86] for the same diagnosis (F23.3). This relatively low prevalence suggests that while delusional symptoms are significant, they are less commonly the primary feature of acute psychotic episodes compared to other symptoms.

Overall, our findings reveal a diverse range of diagnostic categories in acute psychosis, highlighting the variability in clinical presentation and the challenges in achieving diagnostic

consensus. The differences in prevalence rates across studies may be influenced by factors such as diagnostic practices, population characteristics, and study methodologies.

The aim of this study lies in its detailed examination of acute psychosis, highlighting the variability in symptom presentation and diagnostic categories. Our findings demonstrate that certain symptoms, such as persecutory delusions and impaired judgment, are consistently prevalent across different studies, suggesting these as core features of acute psychosis. However, the variability in other symptoms, like grandiosity and affective disturbances, underscores the importance of a comprehensive and individualized assessment approach.

By identifying these patterns and variances, our study emphasizes the need for clinicians to be aware of cultural, environmental, and diagnostic factors that may influence the presentation of acute psychosis. This awareness can lead to more accurate diagnoses and effective treatment plans tailored to the specific needs of patients. Furthermore, our findings support the development of standardized assessment tools that can better capture the diverse presentations of acute psychosis, ultimately improving patient outcomes.

CONCLUSION

This study provides a comprehensive exploration of the sociodemographic and symptomatology and phenomenology of patients diagnosed with acute and transient psychotic disorders (ATPDs) in a general hospital setting in North Karnataka. The findings indicate a significant prevalence of ATPD among young adults, with a higher representation of females and individuals from rural areas. Most participants lacked a family history of psychiatric illness and had no past psychiatric history, suggesting the acute nature of their conditions.

The predominant symptoms included impaired sleep, auditory hallucinations, and decreased social interactions. The Global Assessment of Functioning (GAF) scores highlighted considerable impairment, with the majority of participants scoring in the lower ranges. A noteworthy proportion exhibited catatonic symptoms, with mutism being the most common. Additionally, thought disturbances, particularly delusions of persecution, were prevalent among the participants.

Affective disturbances were also significant, with anxiety and irritability being the most frequent. Hallucinatory experiences were common, primarily auditory in nature. The lack of insight and impaired judgment were consistent features, underscoring the severity of the disorder. Diagnostic subtypes varied, with acute polymorphic psychotic disorder without symptoms of schizophrenia being the most prevalent.

The study underscores the need for further research into the phenomenology and symptomatology of ATPD to enhance diagnostic accuracy and treatment strategies. Understanding the specific characteristics and variations in symptoms can aid in developing targeted interventions, improving patient outcomes, and informing future revisions of

diagnostic criteria. This research contributes valuable insights into the clinical presentation of ATPD, paving the way for more in-depth studies in diverse healthcare settings.

The scope of this study encompasses a comprehensive examination of thought disorders, affective disturbances, and diagnostic profiles among individuals experiencing acute psychosis. By focusing on a diverse sample, the study aims to identify prevalent symptoms and compare these findings with existing literature to highlight both common and unique aspects of acute psychosis across different populations and settings. This broad scope allows for a detailed understanding of the clinical presentation of acute psychosis, contributing to the development of more effective diagnostic and treatment strategies.

The findings of this study enhance the current understanding of acute psychosis by offering detailed insights into demographic trends, phenomenology, and socio-demographic variables.

By comparing these results with previous studies, our comprehension of the intricate nature of acute psychosis is deepened, laying a foundation for future research efforts.

LIMITATIONS

1) The sample size of study was less

2) This is a hospital-based study. Hence, it can’t be generalised to community.

3) Lack of objective diagnostic tools used in this study

SUMMARY

Our study, conducted at the Department of Psychiatry, KLES Prabhakar Kore Hospital from January 1 to December 31, 2023, was a cross-sectional investigation involving 60 patients aged 18 years and older. Patients presenting in both inpatient (IPD) and outpatient (OPD) settings who met the criteria for Acute and Transient Psychotic Disorder (ATPD) according to ICD-10 were included, provided they did not have substance use disorders, intellectual disability, or organic psychosis. Consent was obtained from all participants, with additional consent from caregivers under Section 89 of the Mental Healthcare Act, 2017 for admitted patients requiring high support.

Within the initial 48 hours of admission, data collection included caregiver interviews, detailed Mental Status Examination (MSE), application of the Brief Psychiatric Rating Scale (BPRS), and assessment using the Global Assessment of Functioning (GAF) to evaluate symptomatology and functioning. Diagnoses were based on observed symptomatology, categorizing patients into various subtypes of ATPD.

Key findings indicated a mean patient age of 37.23 ± 14.95 years, with a majority (28.33%) aged 21-30 years and predominantly female. Most patients hailed from rural backgrounds (58.33%) and had completed primary education (56.66%). Unmarried individuals were more in number. Less patients reported a family history of psychiatric illness (21.6%) or past psychiatric issues (16.66%).

The most frequently reported symptoms included sleep disturbances (78.33%), muttering behaviour (46.67%), irritability (41.67%), decreased social interactions (41.67%), and suspiciousness (50% for persecutory and 25% for referential). Common clinical findings encompassed impaired judgment (96.67%), Grade 1 insight (80%), concrete thinking

(93.33%), and affect disturbances (90%), primarily anxiety (35%) and irritability (21.6%). Delusions, particularly persecutory, were prevalent, alongside hallucinatory experiences, though formal thought disorders were less common. Additional symptoms included suicidal ideations (8.33%), somatic preoccupations (8.33%), and various types of hallucinations, with lack of insight and impaired judgment observed in nearly all participants.

Diagnostically, the majority of patients (28.33%) were classified as having Acute Polymorphic Psychotic Disorder without schizophrenia, followed by other types of ATPD (21.67%) and acute polymorphic psychotic disorder with schizophrenia symptoms (20%).

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ANNEXURE - I

INFORMED CONSENT FORM

"DESCRIPTION OF SYMPTOMATOLOGY AND PHENOMENOLOGY OF ACUTE AND TRANSIENT PSYCHOTIC DISORDER: A ONE YEAR HOSPITAL BASED CROSS-SECTIONAL STUDY"

Name of Student/Principal Investigator: _____

Name of Guide/Co Investigators: _____

Objective:

- TO DESCRIBE THE SYMPTOMATOLOGY AND PHENOMENOLOGY IN PATIENTS OF ACUTE AND TRANSIENT PSYCHOTIC DISORDER
- TO DESCRIBE THE DIAGNOSTIC SUBTYPES

Introduction: Acute and Transient Psychotic Disorder (ATPD) is a common psychotic phenomenon occurring frequently in a developing country like India. The prevalence of ATPD ranges between 9%-14%. The clinical manifestation of ATPD has a polymorphic picture. Its symptomatology and phenomenology is not seen in any other psychotic illness. Major proportion of ATPD cases present commonly to General Hospital Psychiatry Unit (GHPU). Several subgroups of ATPD are defined in ICD-10 DCR, which include Acute polymorphic psychotic disorder with / without symptoms of schizophrenia, Acute schizophrenia-like psychotic disorder and Other acute predominantly delusional psychotic disorder. This disorder differs from schizophrenia in various aspects. Till date very little is known about the clinical manifestations, its patterns and phenomenology.

Explanation of procedure: Written consent will be taken from all the Participants/Attenders/Caregivers. Socio demographic details and medical details of the patients would be collected who come to the IPD and OPD setting. Details regarding neurological disorders, intellectual disability and mental and behavioural disorder due to substance use to be ruled out. All patients falling under the exclusion criteria will be ruled out. All patients who meet the inclusion criteria will be subjected to Mental status examination.

ICD-10, DCR, F23 criteria, Global Assessment of Functioning (GAF, APA, 1994), Brief psychiatric rating scale will be applied to assess the above objectives.

Withdrawal from participation in the study: Participation in this study is voluntary. You will be free to decide whether to participate in this study or continue participation once enrolled. In case you decide to withdraw your participation, you are free to do so. However, please convey the decision to the principal investigator.

Possible benefits from participating in the study: You will/will not have nor get any benefits by participating in this study. The data gathered will help the population at large.

Possible risks from participating in the study: There are no risks involved in participating in this study.

Privacy and confidentiality: The information collected from you will be coded, to prevent any person from identifying you. Your identity will never be revealed. The data collected from you will be kept confidential and only processed or aggregated data will be used for publication.

Financial incentives: You will not receive any payment for participating in this study.

Authorization for publication of aggregated data: Results obtained after processing of the aggregated data will be published for scientific purposes and or presented to scientific groups. However, your identity will never be revealed.

Questions: In case of any questions with regard to this study, you are free to contact: "Name of student/PI, mobile number, email ID" If you have any question or complaints with regard to your right as study participant you may contact Dr Harsha Hegde, Chairperson, Ethical committee of JNMC, 0831-2473777 Extension 4052.

Legal rights: By signing this consent form, we are not waving any of your legal rights.

CONSENT STATEMENT

I am making a voluntary decision to participate in the study "**DESCRIPTION OF SYMPTOMATOLOGY AND PHENOMENOLOGY OF ACUTE AND TRANSIENT PSYCHOTIC DISORDER: A HOSPITAL BASED CROSS-SECTIONAL STUDY**". My signature below indicates that I have decided to participate and I have read the information provided above or the information provided above has been read to me in the language that I understand best. I was given the opportunity to ask questions and that they have been answered to my satisfaction.

Name of the participant:

Signature or left thumb impression of the participant:

Name of the witness:

Signature or left thumb impression of the witness:

Name of the investigator: _____

Signature of the investigator: _____

ಸಂಶೋಧನಾ ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳಲು ಸಲಹೆ

1. ನಾನು ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳುತ್ತಿದ್ದೇನೆ ಎಂದು ನಾನು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ.
2. ರೋಗಿಯ ಮಾಹಿತಿಹಾಳೆಯಲ್ಲಿ ನಮಾಹಿತಿಯನ್ನು ನಾನುಓದಿದ್ದೇನೆ ಮತ್ತು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ ಎಂದುನಾನು ದೃಢೀಕರಿಸುತ್ತೇನೆ. ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳುವ ಅನುಕೂಲಗಳು ಮತ್ತು ಅನಾನುಕೂಲತೆಗಳ ಬಗ್ಗೆ ಮಾಹಿತಿಯೊಂದಿಗೆಕಾರ್ಯವಿಧಾನವನ್ನು ನನಗೆ ವಿವರವಾಗಿವಿವರಿಸಲಾಗಿದೆ. ಪ್ರಯೋಗದಎಲ್ಲಾ ಅಂಶಗಳನ್ನು ಚರ್ಚಿಸಲು ನನಗೆ ಅವಕಾಶನೀಡಲಾಗಿದೆ, ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳು ಮತ್ತು ಅದರಮೇಲೆ ಈ ಕೆಳಗಿನವುಗಳನ್ನು ವಿವರಿಸಿರುವ ವಿಚಾರಣೆಯಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳಲು ಸಮ್ಮತಿನೀಡಲಾಗಿದೆ.
3. ಈ ಅಧ್ಯಯನದ ಪಾಲ್ಗೊಳ್ಳುವ ನಿರ್ಧಾರ ಸಂಪೂರ್ಣವಾಗಿ ಸ್ವಯಂಪ್ರೇರಿತವಾಗಿದೆ ಮತ್ತು ನಾನು ಆಯ್ಕೆ ಮಾಡಬಹುದು ಎಂದು ನನಗೆ ತಿಳಿದಿದೆ. ಸಮಯದಹಂತದಲ್ಲಿ ಅಧ್ಯಯನದಿಂದ ಹೊರಬರಲು.
4. ವೈದ್ಯಕೀಯ, ವೈಜ್ಞಾನಿಕ ಅಥವಾಶೈಕ್ಷಣಿಕ ಉದ್ದೇಶಗಳಿಗಾಗಿ ನನ್ನ ದೇಹದಸೂಕ್ತವಾದಭಾಗಗಳನ್ನು ಒಳಗೊಂಡ ಕಾರ್ಯವಿಧಾನದ ಛಾಯಾಚಿತ್ರ ಅಥವಾ ರೆಕಾರ್ಡಿಂಗ್ಗೆನನ್ನ ಒಪ್ಪಿಗೆಯನ್ನು ಬಹಿರಂಗಪಡಿಸಲಾಗಿಲ್ಲ ಅಥವಾಚಿತ್ರಗಳನ್ನು ಒಳಗೊಂಡಿರುವ ವಿವರಣಾತ್ಮಕ ಪಠ್ಯಗಳ ಮೂಲಕ ಬಹಿರಂಗ ಪಡಿಸುವುದಿಲ್ಲ.
5. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಮಾಡಿದಪರೀಕ್ಷೆಯಲ್ಲಿ ಯಾವುದೇ ಮಹತ್ವದ ಅಪಾಯವಿಲ್ಲ ಎಂದು ನಾನು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ.
6. ಪಡೆಯಬಹುದಾದ ಫಲಿತಾಂಶಗಳಿಗೆ ಯಾರಿಗೂ ಖಾತರಿ ಅಥವಾ ಭರವಸೆ ನೀಡಲಾಗಿಲ್ಲ.
7. ಮೇಲಿನ ರೂಪವನ್ನು ಅರ್ಥಮಾಡಿಕೊಂಡ ನಂತರ ನಾನುಭಾಗವಹಿಸಲು ಸ್ವಇಚ್ಛೆಯಿಂದ ನಿರ್ಧರಿಸಿದ್ದೇನೆ ಎಂದು ಈ ರೂಪದಲ್ಲಿ ನನ್ನ ಸಹಿಸೂಚಿಸುತ್ತದೆ.

ಭಾಗವಹಿಸುವವರಹೆಸರು / ಕಾನೂನುಬದ್ಧವಾಗಿ ಅಧಿಕೃತ ಪ್ರತಿನಿಧಿ

ಪ್ರತಿನಿಧಿಸಹಿ

ಸಂದರ್ಶಕರ ಹೆಸರು ಮತ್ತು ಸಂದರ್ಶಕರಸಹಿ

ದಿನಾಂಕ:

ಸ್ಥಳ :

अनुसंधान अध्ययन में भाग लेने के लिए सहमति

1. मैं समझता हूं कि मैंअध्ययन में भाग ले रहा हूं |

2. मैं पुष्टि करता हूं कि मैंने मरीज सूचना शीट में जानकारी पढ़ली है और समझली है।अध्ययन में समझाया गया है कि अध्ययन में भाग लेने के फायदे और नुकसान के बारे में जानकारी के साथ मुझे विस्तार से बताया गया है। मुझे परीक्षण के सभी पहलुओं पर चर्चा करने का अवसर दिया गया है,प्रश्न पूछें और इस तरह से ऊपर दिए गए मुकदमे में सहभागिता की सहमति है।

3. यह समझें कि इस अध्ययन में भागलेने का निर्णय पूरी तरह से स्वैच्छिक है और मुझे पता है कि मैं चुन सकता हूं एक समय परअध्ययन सेवा पस लेने के लिए

4. मेडिकल, वैज्ञानिक या शैक्षिक उद्देश्यों के लिए मेरे शरीर के उपयुक्तभाग सहित कार्य करने के लिए प्रक्रिया की तस्वीर या रिकॉर्डिंग के लिए सहमति दी गईहै, बशर्ते मेरी पहचान चित्रों में या उनके साथ आने वाली वर्णनात्मक ग्रंथों में प्रकट नहीं हुई है।

5. मैं समझता हूं कि इस अध्ययन में किए गए किसी भी महत्वपूर्ण जोखिम को शामिल नहीं किया गया है।

6. कोई गारंटी या आश्वासन किसी भी व्यक्ति द्वारा दिए गए परिणाम के रूप में नहीं दिया गया है।

7. इस फार्म पर मेरा हस्ताक्षर दर्शाता है कि मैंने ऊपर की जानकारी समझने के बाद खुशी-खुशी भाग लेने का फैसला किया है।

प्रतिभागी के नाम / कानूनी तौर पर अधिकृत प्रतिनिधि

हस्ताक्षर नाम

गवाह के हस्ताक्षर

साक्षात्कारकर्ता का नाम और हस्ताक्षर

दिनांक:

स्थान :

संशोधन अभ्यासक्रमात सहभागी होण्या साठी संमती

1. मला समजते की मी या अभ्यासात भाग घेत आहे.

2. मी पुष्टी करतो की मी रुग्णमाहिती पत्रकात माहितीवा चली आहे आणि समजून घेतली आहे. अभ्यासात भागघेण्याच्या फायदे आणि तोटेया विषयीमाहिती सहप्रक्रियात पशीलाने मला समजावून सांगितले गेले आहे. मला चाचणीच्या सर्व पैलूंवर चर्चा करण्याची, प्रश्न विचारण्याद्वारे आणि उपरोक्त दिलेल्याचाचणीत सहभागी होण्या ससंमती देण्याची संधी दिली गेली आहे.

3. समजूनघ्या कीया अभ्यासात भाग घेण्याचा निर्णय पूर्णपणे स्वयं सेवी आहे आणि मला याची जाणीव आहे की मीनि वडूशक तोए कावेळेस अभ्यासातून बाहेर पडण्यासाठी

4. वैद्यकीय, वैज्ञानिक किंवा शैक्षणिक हेतूं साठी माझ्या शरीराच्या योग्यभागां सहित कार्या साठी छायाचित्र काढणे किं वा रेकॉर्डिंग करण्या ससंमती देणे म्हणजेमाझी ओळखचित्रां मध्ये किंवा त्यांच्या सोबत असले ल्यावर्णनात्मक ग्रंथां मध्ये उघड झाली नाही.

5. मला हे समजते की या अभ्यासात केलेल्याचा चणी मध्ये कोणते ही लक्षणीय धोका समाविष्ट नाही.

6. कोणतीही हमी किंवा आश्वासन कोणी ही मिळ वूशकतील असे परिणाम म्हणून देत नाही.

7. या फॉर्म वर माझे स्वाक्षरी असे दर्शवते की मी उपरोक्त माहिती समजल्यानंतर सहभागी होण्या चानिर्णय घेतला आहे.

सहभागी चे नाव / कायदेशीर पणे अधिकृत प्रतिनिधी

स्वाक्षरी चे नाव

साक्षीदारांची सही नाव:

मुला खतकाराचे नाव वस्वाक्षरी

दिनांक:

ठिकाण:

ANNEXURE - II

PROFORMA

"DESCRIPTION OF SYMPTOMATOLOGY AND PHENOMENOLOGY OF ACUTE AND TRANSIENT PSYCHOTIC DISORDER: A ONE YEAR HOSPITAL BASED CROSS-SECTIONAL STUDY"

NAME: **INFORMANT NAME:**

AGE: **AGE:**

SEX: **SEX:**

MARITAL STATUS **RELATION:**

OCCUPATION:

ADDRESS:

CHIEF COMPLAINTS:

HISTORY OF PRESENTING ILLNESS:

PAST HISTORY:

FAMILY HISTORY:

MENTAL STATUS EXAMINATION:

GENERAL APPEARANCE AND BEHAVIOUR

CONSIOUSNESS

ORIENTATION:

ATTENTION AND CONCENTRATION:

MEMORY:

INTELLIGENCE:

COMPREHENSION:

ABSTRACTION:

PROVERBS;

SPEECH:

THOUGHT:

MOOD:

PERCEPTION:

JUDGEMENT:

INSIGHT:

GLOBAL ASSESSMENT OF FUNCTIONING SCORE:

BRIEF PSYCHIATRIC RATING SCALE SCORE:

DIAGNOSTIC SUBTYPE:

ANNEXURE-III

TOOLS

BRIEF PSYCHIATRIC RATING SCALE

NAME: _____ DATE: _____
PATIENT ID#: _____ MD: _____

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Please enter the score for the term which best describes the patient's condition.

0 = not assessed, 1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, 7 = extremely severe

1. **SOMATIC CONCERN** Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not. SCORE ☐	10. **HOSTILITY** Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety, nor somatic complaints. (*Rate attitude toward interviewer under "uncooperativeness"*). SCORE ☐
2. **ANXIETY** Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms. SCORE ☐	11. **SUSPICIOUSNESS** Brief *(delusional or otherwise)* that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances. SCORE ☐
3. **EMOTIONAL WITHDRAWAL** Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation. SCORE ☐	12. **HALLUCINATORY BEHAVIOR** Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people. SCORE ☐
4. **CONCEPTUAL DISORGANIZATION** Degree to which the thought processes are confused, disconnected, or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning. SCORE ☐	13. **MOTOR RETARDATION** Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level. SCORE ☐
5. **GUILT FEELINGS** Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses. SCORE ☐	14. **UNCOOPERATIVENESS** Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation. SCORE ☐
6. **TENSION** Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient. SCORE ☐	15. **UNUSUAL THOUGHT CONTENT** Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes. SCORE ☐
7. **MANNERISMS AND POSTURING** Unusual and unnatural motor benavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here. SCORE ☐	16. **BLUNTED AFFECT** Reduced emotional tone, apparent lack of normal feeling or involvement. SCORE ☐
8. **GRANDIOSITY** Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation. SCORE ☐	17. **EXCITEMENT** Heightened emotional tone, agitation, increased reactivity. SCORE ☐
9. **DEPRESSIVE MOOD** Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints. SCORE ☐	18. **DISORIENTATION** Confusion or lack of proper association for person, place or time. SCORE ☐

GLOBAL ASSESSMENT OF FUNCTIONING

Global Assessment of Functioning (GAF) Scale

(From DSM-IV-TR, p. 34.)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	(Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)
100 | 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
90 | 81	**Absent or minimal symptoms** (e.g., mild anxiety before an exam)**, good functioning in all areas, interested and involved in a wide range of activities. socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g. an occasional argument with family members).
80 | 71	**If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational or school functioning** (e.g., temporarily failing behind in schoolwork).
70 | 61	**Some mild symptoms** (e.g. depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household)**, but generally functioning pretty well, has some meaningful interpersonal relationships.**
60 | 51	**Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g.. few friends, conflicts with peers or co-workers).
50 | 41	**Serious symptoms** (e.g.. suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).
40 | 31	**Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 | 21	**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).
20 | 11	**Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).
10 | 1	**Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
0	Inadequate information.

CATATONIA	PSYCHOMOTOR ACTIVITY	ATTENTION	CONCENTRATION	ORIENTATION	IMMEDIATE MEMORY	RECENT MEMORY	REMOTE MEMORY	THINKING	THOUGHT	PERCEPTION	AFFECT	INSIGHT	JUDGEMENT
,1,3,12,14,16	3	1	1	1	1	1	1	1	1,11,18	1	4	1	2
0	2	2	2	1	1	1	1	1	1,2	2	3	1	2
0	2	2	1	2	2	1	1	1	1,12	1	3	2	2
3,4,5,14	3	2	1	1	1	1	1	1	1,3	2	8	1	2
0	1	1	2	1	1	1	1	1	1	1	4	1	2
0	2	2	1	1	2	1	1	1	4,5,6	4	3	1	2
0	1	2	2	1	2	1	1	1	6,7	1	4	3	2
3,5,11	2	1	2	1	1	1	1	2	4,9	3	3	1	2
0	1	2	2	1	1	1	1	1	1,2	1	9	1	2
0	2	2	1	1	1	1	1	1	2	2	3	1	2
4,3,5,11	2	1	2	1	1	1	1	1	11	2	6	1	2
3,5,11,9,14	3	2	2	1	1	1	1	1	12	1	8	1	2
0	3	1	1	1	2	1	1	1	14,1	8	4	1	2
0	1	2	2	2	1	1	1	1	3	4	3	1	2
0	3	2	2	1	1	1	1	1	1,19	1	4	1	2
,3,4,5,13,14,19,	3	2	1	1	1	1	1	1	1	9	3	1	2
0	2	2	2	1	2	1	1	1	15	2	3	1	2
0	1	2	2	1	1	1	1	2	8,6,3,2	2	5	1	2
0	1	2	1	1	1	1	1	1	1,11,13	10	3	1	2
0	1	1	2	1	1	1	1	1	17,1,6,3	1	3	2	2
0	2	2	2	1	2	1	1	1	1,17,	1	4	1	2
0	1	1	1	1	1	1	1	1	2	2	4	1	2
0	1	2	2	1	1	1	1	1	2,4	5	3	2	2
5,9,11,12,19	3	2	2	1	1	1	1	1	1,8,7	4	3	1	2
0	3	2	2	1	2	1	1	1	6	3	4	2	2
0	3	2	2	2	1	1	1	1	4	3	3	1	2
0	2	2	2	1	1	1	1	1	3	1	1	1	2
0	3	2	1	1	1	1	1	2	11,12	9	1	1	2
0	3	2	2	1	2	1	1	1	3	1	2	1	2
0	3	2	2	1	1	1	1	1	1	2	3	1	2
0	3	2	1	1	1	1	1	1	2,3	4	4	1	2
0	1	1	2	1	1	1	1	1	2	3	3	1	2
3,4,11,14	3	2	2	1	2	1	1	1	16	10	8	3	2
0	1	1	2	1	1	1	1	1	12	1	4	1	2
0	1	2	2	1	1	1	1	1	1,11,13	0	4	0	0
0	1	2	2	3	2	1	1	2	1,11,18	7	7	1	2
0	1	1	2	1	1	1	1	1	1	1	3	1	2
0	1	2	1	1	1	1	1	1		0	8	1	2
0	1	2	2	1	1	1	1	1	1,11,18	0	8	1	2
0	2	1	1	1	2	1	1	1	2,8,9,10,7	1	5	1	2
0	1	2	1	1	1	1	1	1	1,16	1	1	1	2
3,11,12,14,1,17	2	1	2	1	1	1	1	1	1	0	8	1	2
0	2	2	2	1	2	1	1	1	1,3	1	4	1	2
0	1	1	1	1	1	1	1	1	1	10	1	1	2
0	2	1	1	1	1	1	1	1	1,13	10	8	1	2
0	2	2	2	1	2	1	1	1	1,3	1	5	1	2
0	2	1	2	1	1	1	1	1	1,20	1	8	1	2
0	1	1	2	1	1	1	1	1	2,3	0	8	1	2
0	1	2	2	1	1	1	1	1	5,9,7	6	4	2	2
0	1	1	1	1	2	1	1	1	2,19	11	8	2	2
0	1	1	1	1	1	1	1	1	1,3	4	1	1	2
0	1	2	2	1	2	1	1	1	1	1	1	1	2
0	1	2	1	1	1	1	1	1	20	1	3	1	2
0	3	1	2	1	1	1	1	1	6,9	2	8	2	2
0	1	2	1	1	2	1	1	1	4,3	1	3	1	2
0	2	1	1	1	1	1	1	1	1,2	0	8	1	2
0	3	2	2	1	1	1	1	1	1,19	2	3	3	2
0	1	1	2	1	1	1	1	1	1,2,11,7	2	3	1	2
0	2	1	1	1	1	1	1	1	1	1	3	0	0
0	1	2	2	1	1	1	1	1	11	2	6	1	2

GENDER	AGE	EDUCATION	DOMICILE	SES	MARITAL SATTUS	FAMILY HISTORY	PAST HISTORY	BPRS	GAF	CHIEF COMPLIANTS	DIAGNOSIS
1	25	2	1	3	2	2	1	34	3	1,2,3,4,8,,10	1
1	72	2	2	2	1	2	1	52	2	11,4,1,10,7	2
0	64	2	1	3	2	1	2	27	4	1,10,4,5,12	4
0	19	3	2	3	1	1	1	40	2	1,5,3,2	5
1	34	2	2	1	1	1	2	42	3	1,15,13,14	1
0	31	1	1	2	2	1	1	45	2	1,14,16,17,12	6
0	40	2	2	3	1	1	1	42	1	18,19,1,12,8	2
0	18	3	2	3	1	1	1	56	2	1,20,18,13,3,10	6
0	36	2	1	3	2	1	1	33	3	1,4,3,13	1
1	37	1	1	2	1	1	1	44	2	13,21,15,1	1
1	40	4	1	3	1	1	1	34	2	3,13,1	2
0	26	2	2	3	2	1	2	40	1	2,3,6,15,12	3
0	28	4	2	1	1	1	1	44	3	22,13,18,3	5
1	38	2	1	2	1	1	2	39	2	1,11,13,15	4
0	63	3	2	2	2	1	1	40	3	1,4,5,13,15,12	6
0	18	1	1	2	1	2	2	44	2	1,3,5,6	1
0	21	2	2	3	2	1	1	33	1	1,16,14	6
1	45	2	1	2	1	2	1	40	3	3,7,17,23,1,8,10	2
0	38	4	2	2	2	1	1	50	1	1,4,5,3,24,10	6
0	56	2	2	3	1	1	1	46	2	1,5,4,18,16	1
0	59	2	1	1	2	2	1	37	3	1,4,5,10,26	1
1	55	1	2	2	1	1	1	40	2	1,4,5,13,10	2
0	40	3	1	3	1	1	1	54	1	1,10,7,3	1
0	45	2	2	3	2	1	1	50	2	1,5,6,10	3
0	47	2	1	2	1	1	1	46	3	1,3,11,15	4
0	18	2	2	3	1	1	1	55	2	1,10,8,20,13,3	1
0	40	3	1	2	2	1	2	57	1	5,47,13,11	3
1	27	2	1	3	2	1	1	59	2	1,24,13,4	2
0	27	2	1	3	3	1	1	44	2	1,5,14,13	1
1	56	1	1	2	1	1	2	40	2	13,16,3	6
0	41	4	1	3	2	1	1	42	3	5,7,1,13	6
0	60	3	2	2	3	1	1	46	2	14,7,1,5	2
0	29	2	1	3	2	1	1	48	1	5,6,1,10	1
0	74	2	2	3	1	2	1	34	3	22,1,13	3
0	68	3	1	2	2	1	1	50	2	1,3,8,17,14	6
0	26	2	1	3	3	1	1	52	1	13,4,11,24	1
1	50	2	1	2	1	1	2	46	2	18,5,4,7,16	6
1	55	2	2	3	1	1	1	39	3	1,5,3,13,24	2
0	28	2	1	2	2	1	1	45	2	1,3,5,12,13,22	1
0	50	3	2	2	1	2	1	60	1	5,7,1,18,19,3	6
0	44	2	1	2	1	1	1	33	4	1,11,4	5
0	26	2	2	3	2	1	1	40	2	15,14,8,1	2
0	21	2	1	2	1	1	1	38	3	13,3,1	3
0	40	2	2	2	2	1	1	34	3	5,4,7,11	1
1	19	3	1	3	2	2	2	50	2	13,15,18,11,5,1,12	5
0	25	2	1	2	1	2	1	59	1	16,4,7,8,5,1	2
0	29	2	1	3	2	1	1	39	2	1,5,3,18,10	3
0	19	4	1	2	2	1	1	42	3	18,13,11,3,7,1	1
0	37	2	1	2	2	2	1	44	3	13,5,15	6
0	40	1	1	3	3	1	1	49	2	5,3,15,1,12	5
0	45	2	2	3	2	1	1	38	3	18,5,4	2
0	28	3	2	2	1	1	1	40	3	18,2,3,11,14,4,5	3
1	21	2	1	3	1	1	1	44	2	14,18,4,12,17	6
0	23	1	1	3	2	1	1	50	1	3,4,7,13,10	1
0	28	3	2	2	1	2	1	34	3	13,3,1,15	2
0	20	2	1	2	2	2	1	49	2	1,12,4,10,5	5
0	43	4	2	3	2	1	1	37	3	7,1,2	1
0	32	1	2	2	1	1	1	59	2	4,5,24,1	6
0	18	2	1	1	3	1	1	47	3	15,4,1,10	5
0	32	1	1	3	1	2	2	55	1	16,21,1,12,24	5