ACUTE PSYCHOTIC DISORDERS

DEFINITION

- ICD 10: ‘Acute & transient psychotic disorder’- Psychotic conditions with onset within 2 weeks and full remission within 1-3 months.
- DSM 5: ‘Brief psychotic disorder’ Psychotic condition that involves the sudden onset of psychotic symptoms, which lasts 1 day or more but less than 1 month. Remission is full & the individual returns to the premorbid level of functioning

THIRD PSYCHOSIS?

- Emil Kraepelin – Dichotomy of functional psychoses
  - Dementia Praecox
  - Manic-Depressive insanity
- Did not take into account functional psychotic disorders with
  - an acute onset
  - short course
  - good outcome

THIRD PSYCHOSIS?

- Included disorders referred to as :-
- Acute psychoses
- Atypical psychosis
- Reactive psychosis
- Psychogenic psychosis
- Hysterical psychosis
- Cycloid psychosis
- Bouffee delirante

Third Psychosis

Amentia-

- Theodor Meynert (1833 to 1898),Emil Kraepelin (1856 to 1926)
- a psychotic disorder with a remitting course and favorable outcome,

Cycloid psychosis-

- Two variants - Karl Kleist (1879–1960):
- Confusional insanity - contrasting phases of confused excitement and stupor, and
- motility psychosis - contrasting phases of hyperkinesis and akineses.
- A 3rd variant, anxiety-elation psychosis - Karl Leonhard (1904–1988).
- Still used by German, Scandinavian, & other European psychiatrists
- Influential for the formulation of ATPDs in ICD-10.

Third Psychosis

Bouffée délirante (Legrain, Magnan)

- influential in formulating ICD-10 ATPDs.
- Common in Africa and the Caribbean, so categorized as a culture-bound syndrome in the DSM-IV-TR.

Psychogenic or reactive psychosis

- A psychotic disorder with acute onset following external stress
- popular among Scandinavian psychiatrists

Hysterical psychosis

- sudden and dramatic onset related to a profoundly upsetting event in the context of a "hysterical" personality

Country	Type
France	Bouffee Delirante
Germany	Motility Psychosis Cycloid Psychosis Reactive Psychosis
Scandinavia	Psychogenic psychosis Schizophreniform Psychosis
America	Remitting Schizophrenia Good Prognosis Schizophrenia Hysterical Psychosis Acute Schizoaffective Psychosis

Country	Type
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

THIRD PSYCHOSIS?

- 3 National traditions drew attention to these disorders:
- French concept of "Boufee Delirante"
  - **Magnan, 1886 ; Legrain, 1890**
- German school of "Cycloid Psychoses"
  - **Kleist, 1928; Leonhard, 1962; Perris, 1974**
- Nordic or Scandinavian concept of "Reactive/Psychogenic psychoses"
  - **Wimmer 1916; Faergeman, 1963; McCabe, 1975**
- In India ,first reports on Acute psychoses were published by **Dr. N.N.Wig** from Chandigarh

- Common features of the above concepts:
  - Acute or sudden onset
  - Early age of onset, b/w 20 – 40 years
  - Marked emotional turmoil
  - No evidence of emotional withdrawal.
  - Brief duration of the psychotic illness
  - No family history of schizophrenia
  - Family H/O mood disorder
  - Association with a clear precipitant
  - Good pre morbid adjustment
  - Rapid , complete recovery
- Did not fit descriptions of affective or schizophrenic disorders.

HISTORY

- 1876 – Karl Westphal – **Akute primare Verruckheit/Paranoia acuta**
- 1890 – Theodore Meynert – "**Amentia**" –
  - acute onset
  - confusion,perplexity, agitation, rapidly changing vivid hallucinations, delusions, misidentification phenomena, anxiety and apprehension
  - Full recovery - few weeks/months

HISTORY

- Karl Kleist(1879-1960) – "**Marginal psychosis**" (Randpsychosen)
- Added deep feelings of happiness or ecstasy, motility disturbances-akinetic/hyperkinetic, mood swings, rapid change in symptoms within an episode
- 2 variants:
  - **Confusional insanity** : phases of confused excitement and stupor
  - **Motility psychosis** : hyperkinesis and akineses
- Karl Leonhard – 3rd Variant – **Anxiety elation Psychosis** (1964)- "**Cycloid**"

HISTORY

- Magnan , Legrain (1895)- **Bouffees delirantes/ delire d emblee**(immediate delusion) – culture bound syndrome (DSM IV TR) – caused by "degeneration"(Morel's theory)
- Bleuler (1911) – "acute schizophrenia"
- Wimmer(1916) –**Psychogenic/reactive psychosis** –follows psychosocial trauma
- Mayer Gross (1924)– "**Oneroide Erlebnisform**" –oneiroid states

HISTORY

- Kasanin (1933)- **Acute schizoaffective psychoses**
- Gabriel Langfeldt (1935) - **Schizophreniform Psychoses**
- Meduna(1939)- **Oneirophrenia**(dream like quality of perceptions) – endocrinological basis
- Ey (1954)-**Bouff'ees delirante et psychoses hallucinatoires aigues**
- Holander , Hirsch(1964) - **Hysterical psychosis** – Hysterical personality

EPIDEMIOLOGY

- Data limited – paucity of research
- Mainly international studies – industrialized countries
- 1st episode psychoses study - Nottingham, England -1.36/1 lakh
- 10 fold higher incidence in developing countries.
- Age of onset –Mid 20s(developing) – 20-30s(developed)

EPIDEMIOLOGY

- Most common ICD 10 diagnosis - **polymorphic psychotic disorder without symptoms of schizophrenia** –(33-50%)
- Studies on Brief psychotic disorder(BPD) in Germany – 2-2.5%
- Nearly **twice** more in women
- Lifetime prevalence -0.05%(.08% men,.02% women)

ETIOLOGY

- Little known
- **Biological**– H/o antecedent febrile illness(47% - India) –due to infectious diseases
- **Physiological** –HPA axis abnormalities in female patients with atypical psychoses (Japan)
  - Auditory evoked potential studies – High P300 amplitude in left hemisphere
  - Increased hemispherical blood flow during episodes
  - No Difference noted on CT scan imaging & electrophysiological studies

ETIOLOGY

- **Family/Genetic studies** –Very few
  - India -Higher risk of ATPD , lower risk of schizophrenia & mood disorders in the **1st degree relatives** of probands compared with schizophrenia pro-bands
- **Sociocultural** – Rapid cultural change & modernization – loss of status, role confusion –increased vulnerability
- **Acute Stress**
  - Lack of clear definition (10-69% range)
  - Recall bias
  - Vary in social context(Women – parental home, Men –job related problems

NOSOLOGY – DSM

DSM III

- Brief reactive psychosis lasting **< 2wks**, significant psychosocial stressor, involved emotional turmoil & one of
  - loosening of associations,
  - delusions,
  - hallucinations,
  - disorganised / catatonic behaviour.

DSM III R

- Allowed extension of duration to **1 month.**

NOSOLOGY – DSM

DSM IV & IV TR

- BRP replaced by "**Brief psychotic disorder**" -
  - eliminated identifiable stressor,
  - removed emotional turmoil.
  - Aim- broaden the scope of diagnosis of BPD.

DSM IV TR – 2 specifiers :-

- Differentiates with & without **marked stressor.**
- **postpartum onset** starting within 4 weeks of postpartum period

COMPARATIVE NOSOLOGY

- ICD 10 – ATPD - more elaborate with specific categories
- If criteria compared with DSM IV - would be categorised as BPD, schizophreniform disorder or psychosis NOS.(No specific section)
- DSM IV field trial – "ICD 10 diagnosed ATPD" –
  - 42% -schizophreniform
  - 21% psychotic disorder NOS
  - 13% brief reactive psychosis
  - (based on DSM III R)

COMPARATIVE NOSOLOGY

- BUT ,in Germany – DSM IV -
  - 62% BPD
  - 31% Schizophreniform disorder
  - 5% Psychosis NOS
- ? Differences in criteria b/w IIIR and IV

COMPARATIVE NOSOLOGY

- Acute onset is described in DSM-IV-TR as -
  - essential feature of brief psychotic disorder
  - specifier for favorable prognosis in criteria for schizophreniform disorder
- BUT **not a diagnostic criterion** for any of the above DSM-IV-TR diagnoses.(thus , non acute onset got included)

CLINICAL DESCRIPTION – DSM 5

- Presence of one or more psychotic symptoms, including delusions, hallucinations, disorganized speech, and disorganized or catatonic behaviour.
- "Sudden onset"-in text **but not** in diagnostic criteria
- Specifiers - presence / absence of marked stressor(s).
  - Serious surgery or medical illness
  - Immigration
  - War and other mass violence, torture, and even intensive training programs such as military training

CLINICAL DESCRIPTION – DSM 5

- "**with postpartum onset**" - episodes starting within 4 weeks of giving birth.
- Disturbance is not better explained by a depressive or bipolar disorder with psychotic feature, by schizoaffective disorder, schizophrenia, not attributable to the physiological effects of substance or another medical condition.

CLINICAL DESCRIPTION – ICD 10

- ATPD -3 key features-

1) an **acute onset**(change from a state without psychotic features to a clearly abnormal psychotic state, within a period of **2 weeks or less**)
2) presence of **typical syndromes** - basis for the sub categorization into specific disorders
3) presence of associated **acute stress** (within about 2 weeks of onset).

TYPICAL SYNDROMES

- **Polymorphic syndrome**:
- Marked hallucinations, delusions, perceptual disturbances that change from day to day or hour to hour.
- Frequently associated with emotional turmoil – "intense transient feelings of happiness & ecstasy or anxieties & irritability" **BUT** not meeting criteria for mania or depressive episode.

TYPICAL SYNDROMES

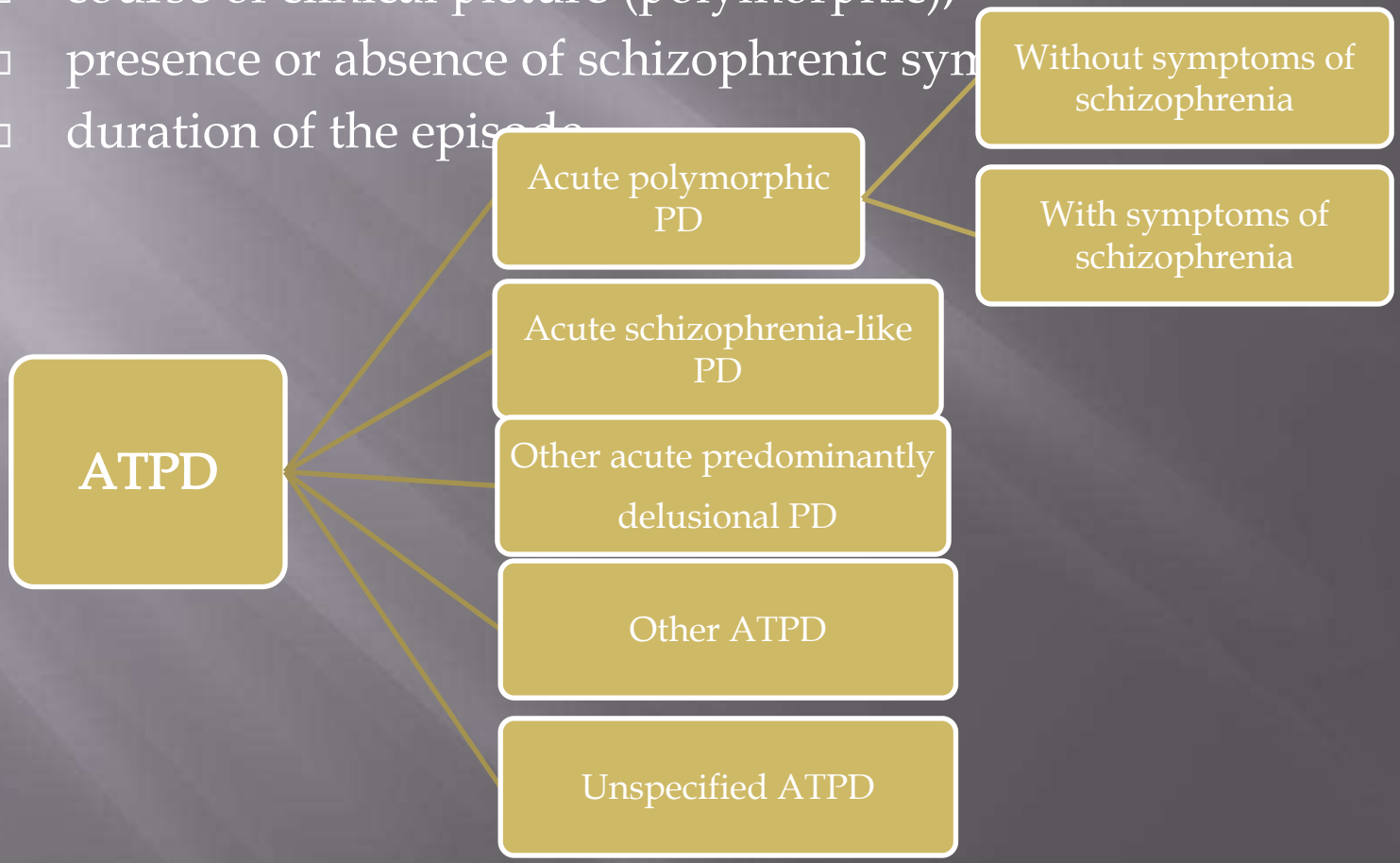
Schizophrenic syndrome:

- Should meet criteria for schizophrenia for majority of time since onset but **duration < 1 month.**
- Can be associated with "polymorphic syndrome"

- "***Acute stress***":
  - "events that would be regarded as stressful to most people in similar circumstances, within the culture of the person concerned."
- Eg.
  - bereavement,
  - unexpected loss of partner or job,
  - marriage
  - psychological trauma of combat, terrorism and torture

CLASSIFICATION IN ICD 10

- The empirical classification in ICD 10 is based on the
- course of clinical picture (polymorphic),
- presence or absence of schizophrenic syn
- duration of the epis



DIAGNOSIS

- **Detailed history :**
- From parents, relatives, spouse / friend regarding :
  - stressors
  - level of functioning before onset of illness,
  - history of response to similar stressors in past.
- History of onset, delusion(s) or hallucination(s) & its frequency & rapidity of change.
- R/o medical & substance induced disorders.

DIAGNOSIS

- **Past history** of similar illness which subsided with or without treatment.
- **Family history**
- **Pre-morbid personality**
- **Examination** : **MSE-**
  - consciousness levels
  - disorganised behaviour
  - psychomotor activity
  - rapidly changing /persistent delusion, hallucination
  - emotional status
  - cognitive functions
- **GPE & Syst. Examination** : R/O organic etiology

INVESTIGATIONS

- **Routine blood tests :**
  - Haemogram
  - Liver & renal function tests
  - Serum electrolytes
  - Thyroid function tests
- CT, MRI,EEG, LP- R/o organic causes
- No specific lab tests

DIFFERENTIAL DIAGNOSIS

- 1st few days-weeks – provisional diagnosis
- Schizophrenia -F23.1 **> 1 month**
- Delusional disorder/Other nonorganic psychosis –F23.0 **> 3 months**
- DSM 5–psychotic symptoms>1 month ,then
  - Schizophreniform disorder
  - Delusional disorder
  - Mood disorder with psychotic features
  - Psychotic disorder NOS
- Mood Episode- if symptoms better accounted

DIFFERENTIAL DIAGNOSIS

- Psychotic Disorder due to a General Medical Condition / Delirium – evidence from
  - History,
  - Physical examination
  - Lab tests/imaging
- Substance-induced Psychotic disorder,Substance-induced delirium,Substance intoxication –
  - Substance etiologically related
  - Lab tests – urine drug screen /blood alcohol level
  - Temporal relationship (+)

DIFFERENTIAL DIAGNOSIS

- Personality disorders :
  - Psychotic symptoms usually transient –Borderline/schizotypal
- Factitious disorder with Predominantly Psychological signs & symptoms :
  - Evidence of intentional symptom production
- Malingering :
  - Evidence that illness was feigned for an understandable goal

DIFFERENTIAL DIAGNOSIS

- Dementia
- Dissociative identity disorder
- Culture bound syndromes

STUDIES

- Research on ATPD in India has made a significant contribution and this is 1 area where Indian research has made a mark at the international level.
- ATPDs provide a paradigm for study of psychoses that are neither schizophrenic nor affective.

STUDIES

- IPSS(International Pilot-study of schizophrenia (1968-70):
- Substantial proportion (26%) of schizophrenic subjects had good outcome in the form of only one episode
- Patients from developing countries had better outcome(?schiz/other psychosis)

STUDIES

- DOSMeD (Determinants of Outcome of Severe Mental Health Disorders)(1978-80):
  - **Broadly defined** schizophrenias included a group of acute onset, reactive and unspecified psychoses.
  - Patients who had non-affective psychosis and remitted completely(?**NARP**)**Non affective acute remitting psychosis** :10 times higher incidence in developing countries
  - Patients in developing countries exhibited a **benign course** at 2 years follow-up.

STUDIES

- CAP (Cross-cultural study of Acute Psychosis) (1980-1982)
- Acute psychosis :
  - 41.2% -schizophrenic symptoms,
  - 20% affective symptoms
  - 35.3% other psychoses.
- 41.7% -stress close to onset.
- Marked prevalence - below-average socio-economic status.

STUDIES

- 2/3 patients remained well with no relapse at 1 year.
- Outcome in patients of acute psychosis with schizophrenic symptoms = those with only affective symptoms.

- 1979 WHO international follow up study of schizophrenia:
  - Single episodes with full remissions: more frequent in Nigeria & India (58% &51%), whereas chronic progressive course in US & Denmark (47-48%)
  - In some countries (USSR ,Columbia) majority have brief relapses (42% & 39%) & suggested that they may be dealing with 3 different schizophrenias exhibiting different courses rather than a single entity.

INDIAN STUDIES

Chandigarh Acute Psychosis Study:

- Only 60% of acute psychosis fitted the diagnostic criteria of schizophrenia and MDP as per ICD-9 .
- Remaining 40% -
- greater frequency of stress
- undifferentiated symptomatology (polymorphic)

INDIAN STUDIES

ICMR Acute Psychosis study(1981-84)

- Study of phenomenology and natural history of acute psychosis was done at four centres in India (Bikaner, Goad, Patiala, Vellore).
- 323 cases of sudden onset ,full blown psychosis were taken & followed for atleast 1 year, diagnosed based on ICD9 .
- 35% -Schizophrenia, 25%MDP, 40% as non-organic psychosis as per ICD-9
- 52%(161) could not be categorized into any.

INDIAN STUDIES

- Differ based on clinical picture, normal premorbid personality, absent family history, excellent recovery rate.
- Benign type of acute psychosis triggered by psychological or physical stress which tends to recover rapidly within matter of wks or months without residual symptoms.
- Occurrence more in Afro- Asia suggests socio-cultural influences in predisposing factors.

Wig and Singh	First pointed the existence of ATPD in India
Kapur and Pandurangi	2 types of acute psychosis, based on presence or absence of stress
Singh and Sachdeva	pointed "acute schizophrenia episode" shouldn't be included in schizophrenia
Chavan and Kulhara	Reactive psychosis
ICMR	40% of patients with acute onset psychoses don't fit into either diagnosis of schizophrenia, MDP or depression

Most of the research on ATPD has been limited to India and Scandinavian countries

TREATMENT

- **Hospitalization**
- Considered Psychiatric emergencies
- Evaluation and protection(reassuring setting).
- **Goal: Prevent auto/hetero-aggressivity** (suicidal potential, affective symptoms, agitation, aggressive behavior, command hallucinations etc.)
- Assess level of danger to self and others
- Seclusion, physical restraints,1 to 1 monitoring may be necessary.

TREATMENT

PHARMACOTHERAPY

- Some wait 1-2 days to r/o organic causes

2 Major classes used:

- **Antipsychotics**
  - **SGAs** -1st line
  - **FGAs** – 2nd choice/adjunctive
  - Major anxiety/agitated behaviour-**short acting sedative neuroleptics**
  - **Parenteral** if patient refuses oral or if rapid effect reqd.
  - Predominant delusions/hallucinations-high potency like haloperidol/flupenthixol

TREATMENT

Benzodiazepines

- Potentiate neuroleptics action
- Alprazolam,lorazepam – rapid sedation
- Combination preferred
- Doses adjusted and monitored for S/E.
- Avoid long term medications
- **Anxiolytics**-Useful in 1st 2-3wks after resolution

TREATMENT

Continuation treatment

- Effectiveness seen in 6 weeks
- Worsening of symptoms/poor response-ECT indicated

TREATMENT

Prevention of recurrence:

- Possible in 1st 2yrs of follow up.
- Low dosage pharmacotherapy maintained for 1-2yrs.
- Periodic assessment, effective clinical care with social & psychological therapy essential.

TREATMENT

- **Socio-therapy**(occupational/intensive)
- **Psychotherapy**(reality-adaptive-supportive)
  - Exploration & development of coping strategies for stressors
  - Regain self confidence
  - Increasing problem solving skills
  - Strengthen ego structure
  - Family involvement.

RESEARCH

- Research on ATP supports the notion that there is:
  (i) **Genetic distinctiveness of ATP**.
- Although the findings point towards genetic distinctiveness of ATPD, it is hypothesized that
- ATPD may be an environmentally induced psychotic condition superimposed upon an underlying vulnerability to psychosis.
- What type of psychosis the patient is likely to develop, could be related to:
  (ii) **The timings of brain insult**, e.g., early-life insult may lead more often to schizophrenia and later-life insult may lead to ATP.

  (iii) **The severity of brain insult** where ATP may be associated with less severe insult.

  As there are also good outcome schizophrenias, ATP and schizophrenia may lie on a continuum of severity.

- There may be a common genetic liability to psychosis and further distinction between schizophrenia, MDP and ATPD could lie on two dimensions:

  a) Symptoms dimensions, where symptoms of schizophrenia → schizoaffective psychosis → ATPD → affective psychosis with psychotic symptoms → affective psychosis without psychotic symptoms lie on a continuum.

  (b) Course dimension, which may vary from chronic deteriorating → recurrent with varying levels of recovery → single episode with full recovery.

  Complex interplay between genetic, biological and environmental factors could produce different phenotypic variations recognized in contemporary literature as schizophrenia, MDP or ATPD.

COURSE AND PROGNOSIS

- Full recovery in 1-3 months(ICD criterion)
- Most of recovered patients remain well in ensuing years.
- Recurrence rates(39-47%)reported but full recovery common.
- Only 6-18% have residual symptoms.
- 12-year follow-up study in India- Favourable long term outcome.
- No studies in industrialized settings.

GOOD PROGNOSIS

- Good Pre-morbid adjustment
- Few pre-morbid schizoid traits
- Severe precipitating stressor
- Sudden onset of symptoms
- Affective symptoms
- Confusion during psychosis
- Short duration of symptoms
- Absence of schizophrenic relatives

DIAGNOSTIC STABILITY

- ATPD:
- India & Denmark:-27-48% had different diagnosis ,1-3ys after index episodes.
- Associated with clinical features:
  - Germany:- 30% of acute schizophrenia like & 67% of other subtypes maintained original diagnosis on follow up.
  - Japan:- 67% retained F23.0 diagnosis on 20 yr follow up
- Gender dependence:
  - Britain : Diagnosis of 73% women and only 14% men unchanged at 3 yrs follow up. Most changed to schizophrenia/ mood disorder.

DIAGNOSTIC STABILITY

- **BPD**: Prospective Epidemiological study in NY- 6 mths F/U:
- **27%- retained** brief psychotic disorder,
- 9% schizophreniform disorder, 18% psychosis NOS, Mood disorder- 27%, schizophrenia 9%, others 9%.
- Germany :-**83% maintained** diagnosis by 2yrs,70% had relapses.
- Brazil:- only 23% maintained BPD at end of 1yr.
- Overall prognosis is likely to vary with diagnostic stability in an individual patient.

PROPOSED CHANGES –ICD 11

- A diagnostic classification of **Nonaffective acute remitting psychosis (NARP),**also termed as **acute brief psychosis**
- Delineated from schizophrenia and the affective psychoses and considered as a single diagnosis.
- **4 criteria** would be central to the diagnosis:
  1) **nonaffective**
  2) acute onset (over **< two weeks**),
  3) recovery within a brief duration (**< six months**)
  4) psychosis broadly defined.

COMMENTS

- Even after its introduction in ICD-10 by WHO, ATPD still remains inadequately undefined.
- WHO itself pointed out that the present state of knowledge does not allow the reliable definition of this group and its subgroups.
- There is no systematic clinical knowledge and no reliable multiaxial system for their allocation to diagnostic categories. Evidently, more research on the topic is necessary (WHO 1992).

COMMENTS

- The introduction of the categories ATPD in ICD–10 and BPD in DSM–IV has allowed for coding of patients with a single episode of illness.
- However, there is also a need to categorise people who present recurrently with such episodes.
- Future classification should consider such a category.

COMMENTS

- Some authors have presented evidence that a substantial number of remitting psychoses might have a longer duration than the 1-3 months allowed by ICD-10 criteria.
- Not always easy to determine if a specific stressor was a precipitant or consequence of illness.

COMMENTS

- Definitive diagnosis of ATPD/ BPD early in the first episode is difficult, unless psychosis has fully remitted duration of illness cant be determined & therefore usually provisional diagnosis is given.
- Treatment & maintenance therapy & follow ups following first episode is still unclear.
- More studies required of etiology.

CONCLUSION

- Acute and Transient psychotic disorders have disproved Kraeplin's dichotomy.
- ATPD disorders are eminently treatable and have a good long term course and favorable outcome.
- Further studies are needed where in existing criteria and subtypes are used.

CONCLUSION

- Family, genetic and imaging studies are needed to firmly establish acute and transient psychotic disorders as a distinct clinical entity.
- ATPD poses a major challenge to psychiatrists in India & the developing world for insights, lends the best opportunity to them for research.

THANK YOU