Case Report on Acute Transient Psychotic Disorder

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Authors’ contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Introduction: Acute and Transient Psychotic disorder (ATPD) is defined by the ICD-10 as hallucinations, delusions, and/or senseless or nonsensical speech having an acute [1]. The distinguishing characteristic of ATPD is its abrupt onset. Second, there are characteristic symptoms present, and third, there is related acute stress [2].

Clinical Findings: Sleep disturbance, aggressiveness, muttering to self, irritability, irrelevant talks and loss of appetit, hearing of voices not heard by others, suspiciousness, increased talkativeness, increased energy and fearfulness.

Mental Status Examination: Conscious, dressed appropriately, well groomed, standing, eye to

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eye contact initiated, non cooperative, activity normal, and the mood is exhausted, frustrated, the affect is irritable, guarded, and the flow of speech rate is rapid with moderate volume and responsive quality. Thought-flight of thoughts is evident, as are perceptual abnormalities- auditory hallucination, impaired social judgment, and full denial of sickness.

**Outcome:** After treatment, the patient shows improvement. Irritability has reduced, sleeping pattern is improved, self muttering has stopped, irrelevant talks are less, and aggressiveness is reduced.

**Conclusion:** Patient was admitted to Psychiatric Ward with a known case of Bipolar Affective Disorder and after Mental Status Examination he is diagnosed as Acute Transient Psychotic Disorder with complain of Sleep disturbance, aggressiveness, muttering to self, irritability, irrelevant talks. He improved after receiving adequate treatment, and the treatment was continuously ongoing until my last date of care.

**Keywords:** Psychotic disorder; transient; hallucination; delusion.

### 1. INTRODUCTION

Acute and Transient Psychotic Disorder (ATPD) is defined by the ICD-10 as hallucinations, delusions, and/or senseless or nonsensical speech having an acute onset [1]. The distinguishing characteristic of ATPD is its abrupt onset. Second, there are characteristic symptoms present, and third, there is related acute stress [2]. ATPD appears to be more common among immigrants, especially foreign domestic workers. In comparison to schizophrenia, ATPD had a distinct family history, course, and result [3].

The incidence of ATPD was 9.6 per 100 000 population, with a higher rate of females than males (9.8 vs 9.4). Incidence rates by age group were higher for males than for females [4]. ATPD was described as an acute psychosis with brief onset and polymorphous symptomatology (WHO, 1993) [5]. ATPD patients showed better social adaptation, less psychological impairment, and better global functioning than PS patients. These data support the delineation of ATPD from schizophrenia [6].

#### 1.1 Patient Identification

Patient was 33 year old male brought by his mother in psychiatric ward with the known case of bipolar affective disorder. His weight is 65kg with height 174cm.

#### 1.2 Present Psychiatric History

Since ten days prior to admission in the psychiatric ward the patient was aggressive and also abusive behavior towards his family and other, he has difficulties in falling asleep, the mother of the patient also said that he is talking to himself and also hear voices no one is able to here with irrelevant talks that cannot be understand by family member, he tends to have been irritated by small things. He is not eating regularly by saying he is not hungry, he suspicious toward family, had increased talkativeness, increased energy, and fearfulness.

#### 1.3 Past Psychiatric History

Patient was diagnosed as bipolar affective disorder 12 year ago. He had a chronic case of bipolar affective disorder; after hospitalization and treatment his condition was improve and was discharged from hospital with regular follow up treatment. Since then he is visiting the psychiatrist for his follow-up treatment. But from three years he had stop the treatment.

#### 1.4 Present Medical History

Patient is not suffering from any chronic medical disorder such as hypertension or diabetes mellitus. But have the present complain of sleep disturbances and loss of appetite since five days.

#### 1.5 Past Medical History

Patient did not have any chronic medical disorder. He had suffered from viral fever 6 month ago.

#### 1.6 Family History

There are four members in my patient family. His parent had non-consanguineous marriage. All the other member of family is not suffering from any psychiatric disorder except for the patient who is suffering from ATPD.
1.7 Past Intervention and Outcome

At the age of 18, the patient was diagnosed with bipolar affective disorder. He suffered from bipolar affective illness, which he had for a long time. Tab. Sodium valproate 500mg BD, Tab. Oleanz 20mg HS and Lorazepam 2mg OD, Inj. Haloperidol 5mg BD were administered as treatments to make the patient's condition less dangerous to himself and others. He began to show indications of recovery after a few days. Then to Tab. Sodium Valproate 500mg BD, Tab. Oleanz 20mg HS and Lorazepam 2mg SOS. He was discharged from the hospital once his health stabilized, and he continues to see the psychiatrist for follow-up care.

2. CLINICAL FINDINGS

At the time of admission the patient had Sleep disruption, aggression, mumbling to oneself, irritability, aggressiveness, irrelevant discussions and loss of appetite, hearing voices not heard by others, suspiciousness, increased talkativeness, increased activity, and fearfulness were all clinical findings. Irritability remained a few days after therapy, but the patient was less aggressive and damaging. His sleeping pattern had improved, and his eating had improved as well, but irrelevant conversations remained, and he was still talking to himself.

2.1 Physical Examination

There are not many abnormalities found in head to toe examination, the patient has moderate weight and average height. He is irritable and non co-operative.

2.2 Mental Status Examination

Conscious, dressed appropriately, well groomed, standing, eye to eye contact initiated, non cooperative, activity normal, and the mood is exhausted, frustrated, the affect is irritable, guarded, and the flow of speech rate is rapid with moderate volume and responsive quality. Thought-flight of thoughts is evident, as are perceptual abnormalities- auditory hallucination, impaired social judgment, and full denial of sickness.

2.3 Diagnostic Assessment

2.3.1 Blood test

Hb – 14.9gm%, Total RBC count – 4.97 millions/cu mm, RDW – 12.9%, HCT – 20.2%, Total WBC count – 8200/cu mm, Monocytes – 04%, Granulocytes – 74%, Lymphocytes – 20%.

2.4 Management

Tab. Sodium valproate 500mg BD, Tab. Oleanz 20mg HS, Tab. Trinicalm forte HS,Inj. Lorazepam 2mg sos, Inj. Haloperidol 5mg SOS, Inj. Phenargan 25mg SOS.

2.5 Nursing Management

This case belonged to mental health department; therefore nursing care played a vital role in every aspect.

Table 1. Nursing diagnosis: Altered sleep and rest, related to depressed mood and depressive cognitions evidenced morning by difficulty in falling asleep, early morning awakening.

| Nursing Interventions | Rationale |
|-----------------------|-----------|
| Schedule activities for the patient during the day based on his or her interests; do not leave him alone. When the patient is getting ready to sleep, make sure the room is quiet and serene. Assist with relaxation (back rub, tepid bath, warm milk, etc.) Allowing the patient to sleep for an extended period of time throughout the day is not recommended. As directed, provide sedatives at bedtime, have a brief conversation with the patient. Do not engage in long discussions. | To get better night time sleep Talking to the patient might make him feel better, but extended conversations can lead to depressed thoughts. |
Table 2. Nursing diagnosis: Altered communication process related to depressive cognitions evidenced by being enable to interact with others

| Nursing Intervention | Rationale |
|----------------------|-----------|
| Be on the lookout for nonverbal cues. Even though the patient claims to be cheerful, he appears to be unhappy. Bring out the contradiction between what he says and how he feels. Shorten your sentences. Ask inquiries that require the patient to respond with more than one word. Use quiet in a way that does not communicate worry or discomfort. Introduce the patient to a quieter patient who may be recovering from depression. As he improves, introduce him to other patients to ensure that he is accepted as a member of the group. | To make it easier to respond and communicate When a circumstance calls for quiet, it may be beneficial. When dealing with someone who isn’t a member of the staff, there is less worry. Communication is much easier with the help of a group. |

Table 3. Nursing diagnosis: Disturbed sensory-perception (auditory visual) related to panic anxiety, possible hereditary or biochemical factors evidenced by inappropriate responses, disordered thought sequencing, poor concentration, disorientation, withdrawn behaviour.

| Nursing Intervention | Rationale |
|----------------------|-----------|
| Nurses must be patient, show acceptance, and listen actively. Examine the form of hallucinations and their characteristics. Inquire as to what the voices are saying and who is speaking. To avoid rewarding improper conduct, avoid further mention about hallucination. Examine the patient for hallucinatory behaviour such as talking to himself, laughing at oneself, or pausing in the middle of a sentence. Determine any conditions that may have contributed to the patient's hallucinations. Call the patient's name or use another distraction to break up the hallucination, or move the patient to a different place with a movie. Be on the lookout for signs that the patient is hallucinating. Assist the patient in recognizing the link between anxiety and hallucinations. Help the patient understand that humming or whistling or saying "go away" or "be silent" might help him reject hallucinations. | Establishing a trustworthy To see if the hallucinations are command hallucinations To see if the hallucinations are command hallucinations, in which the patient is told to injure himself or others. The key to an effective intervention is to listen and observe. Identifying stresses may assist in reducing the degree of hallucinations. With fewer stimuli, there are less chances for misinterpretation. Hallucinations may be avoided if the patient learns to recognise and stop increasing worry. It aids in the treatment of hallucinations. |

3. DISCUSSION

When patient was admitted he abusive towards his family and friends and do not tends to trust them. He was brought by his mother. He was a known case of bipolar affective disorder and the psychiatrist had advise him to take regular treatment but he has stopped taking his medication and after months he had increased symptoms of aggressiveness and delusion. After the admission in the hospital he was diagnosed as ATPD and his treatment was started after few days he shows sign of improvement then the treatment was again modified. After two weeks he was discharged when he was stable and was advised to take regular medication and follow up care.

The main objective of this case study is to review the literature related to the diagnostic stability of ATPD in developing countries. According to the literature search, the stability percentage of the ICD-10 ATPD diagnosis is 63-100%. The diagnostic shift is more commonly either towards
bipolar disorder or schizophrenia, if any. Shorter duration of illness (<1 month) and abrupt onset (<48 hours) predict a stable diagnosis of ATPD. Based on available evidence, the diagnosis of ATPD appears to be relatively stable in developing countries [7].

During pandemic outbreak, a 20-year-old man went to the hospital repeatedly because he suspected that he was infected, with suspicious auditory hallucinations, self-laughter, primary delusions, victimization delusions, relationship delusions, and suicide attempts. He was diagnosed with Acute Transient Psychotic Disorder. 0.1 g bid Quetiapine was given orally, then gradually increased to 0.4 g per day, supplemented by cognitive therapy. The patient was discharged from hospital in relief of symptoms on February 9th [8].

The objective of this case is to investigate differences between ATPD and BSAD. ATPD differs significantly from BSAD on various relevant levels, such as gender (more female), age at onset (older), development of the full symptomatology (more rapid), duration of the symptomatology (shorter), acuteness of onset (more acute), preceding stressful life-events (more frequent) and long-term prognosis (better). It is concluded that ATPD and BSAD are different nosological entities [9].

The objective of this case is to find out whether there are predictors of suicidal behaviour in ATPD. Multivariate analysis revealed that acute stress and substance use are significantly associated with suicidal behaviour in ATPDs. To our knowledge, this is the first study identifying independent risk factors that could predict suicidal behaviour in individuals with ATPD [10].

4. CONCLUSION

Patient admitted to Psychiatric Ward with a known case of Bipolar Affective Disorder, and after a Mental Status Examination, he was diagnosed with Acute Transient Psychotic Disorder. At the time of admission he had complaint of sleep disturbances, aggressiveness, muttering to himself, irritability, and irrelevant talks. His treatment began as soon as he was diagnosed with ATPD. After the treatment is initiated his symptoms of aggressive behaviour has in control but he was easily irritated and has disturbance while sleeping. He improved after some days of more treatment his irritability was decreased, and the treatment was continuously ongoing until my last date of care.

CONSENT AND ETHICAL APPROVAL

As per international standard or university standard guideline patient consent and ethical approval has been collected and preserved by authors.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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