

A cross-sectional study on the socio-demographic characteristics, clinical variables, the role of stressors and phenomenology in patients with acute and transient psychotic disorders in North India

Mahender Singh¹, Dinesh Dutt Sharma², Devesh Sharma³, Sunny Garg^{4*}, Alka Chauhan⁵

¹Post Graduate Resident, Department of Psychiatry, Indira Gandhi Medical College, Shimla, Himachal Pradesh, India.

²Professor, Department of Psychiatry, Indira Gandhi Medical College, Shimla, Himachal Pradesh, India.

³Assistant Professor, Department of Psychiatry, Indira Gandhi Medical College, Shimla, Himachal Pradesh, India.

⁴Senior Resident, Department of Psychiatry, Bhagat Phool Singh Government Medical College For Women Khanpur Kalan, Sonipat, Haryana, India.

⁵Junior Resident, Bhagat Phool Singh Government Medical College For Women, Khanpur Kalan, Sonipat, Haryana, India.

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Abstract

Background: Acute and transient psychotic disorders have benign course and occurs in the presence of identifiable and extremely traumatic stressors (close temporal relation between stressor and development of psychosis) which necessitate clinical investigations. Stressors are also known to affect phenomenology and its content. Aims and **Objectives:** To study the socio-demographic characteristics, clinical variables, the role of stressors and phenomenology in patients with acute and transient psychotic disorders. **Methods:** A cross-sectional observational study was conducted which included 150 patients who met the inclusion criteria and were diagnosed according to ICD-10. A written informed consent was obtained from the patients and/or their family members. Patients' information was recorded on socio-demographic and clinical profile sheet. Thereafter, PSLES and PANSS scales were applied to assess the stressors and phenomenology respectively. **Results:** Most of the patients were female between 15-35 years with mean age of 32.45 years, The majority of the patients were educated, married, unemployed, living in a nuclear family and had a rural background. Most of the patients presented within two weeks of the onset of the illness without any positive family and past history of psychiatric illnesses. Around three-fourths of total patients had stressors preceding the onset of illness. The average value of PANSS was higher in female. Sleep disturbances, delusions, hallucinations, poor rapport, lack of insight and concrete thinking were the most commonly observed symptoms in ATPD patients. **Conclusions:** Maximum patients who developed the illness had psychological stressor/s in their lifetime mainly before 2 weeks of the onset of the illness. It helps to consider the person's life events as a trigger for illness and make decisions regarding treatment accordingly.

Key Words : Phenomenology, Psychosis, PSLES, Stressors.

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Introduction

Acute and transient psychotic disorders (ATPDs), although reported by various researchers, encompass a

broad heterogeneous group, which has no clear uniform definition or nosological status. Most of the earlier studies were usually targeted at gathering more and more evidence to suggest a necessity for a separate diagnostic category to be included in the standard diagnostic system.[1] Long withstanding clinical tradition in several countries, though not based on epidemiological studies, contributes towards the conclusion that whatever the nature of dementia praecox of Kraepelin and schizophrenia of Bleuler, they

*Correspondence

Dr.Sunny Garg

Senior Resident, Department of Psychiatry, Bhagat Phool Singh Government Medical College For Women Khanpur Kalan, Sonipat, Haryana, India.

E-mail: docter.sunny@gmail.com

are probably not the same as acute psychosis.[2] ATPDs are distinct entities which are different from affective psychosis and schizophrenia. Then ATPDs were ultimately included in ICD-10 in 1992 as a descriptive entity under the psychotic disorder with special reference to presence or absence of stress.[1] ATPDs occurs in a variety of socio-cultural settings and have several important features in common, viz. acute onset (within 2 weeks), usually precipitated by stressors, a florid and variable polymorphic clinical picture, short duration and a marked tendency to recover with or without treatment.[3] Investigations of these disorders in the developing countries, where they occurred more frequently, especially with respect to stress as related to psychopathology and short term outcomes, helped in understanding the extent to which these disorders maintain a distinct profile, further implications on its diagnostic validity and their treatment.[4] Psychic equilibrium involves a balance between the individual's adaptive mechanism and stress to which patients are exposed. Imbalance between emotional support and environmental stress precipitates psychiatric ill health. Stress is one of the old warhorses of psychiatry. Stressors, especially in the preceding 3 months, may trigger the first and acute episode of psychosis.[5] Repeated exposure to stress causes dys-regulation of the hypothalamic pituitary adrenal axis which may subsequently give rise to increased dopamine receptor densities, dopamine release and dopaminergic abnormalities commonly thought to be present in psychosis.[6] The existence of stressors or intrapsychic conflicts may have been the identified causative agents but both the magnitude and the multiplicity of such stressors are important as well.[7] Jaspers also stated that the content of the psychosis often reflected the nature of the traumatic experiences and that the development of the psychosis seemed to serve a purpose for the patient, often as an escape from a traumatic condition.[8] It was not only that psychosis developed in association with emotional trauma, but also the course and phenomenology reflected the trauma. Stressors precipitated in patient populations in part due to active phenomenology that impairs adaptive functioning. Demographic variables, ethnicity and cultural variations are also known to affect ATPD phenomenology and its content.[9] Many authors have studied socio-demographic profile of ATPD patients and its relation to stress but only a few authors have addressed phenomenology. As far as we are aware, very few studies like this have been conducted in the past in the Northern India. In view of the above mentioned

facts, the current study of the socio-demographic characteristics, clinical variables, the role of stressors and phenomenology in patients with acute and transient psychotic disorders was planned. So our study was conducted in one of the Tertiary Care Hospitals of North India after getting through the Ethical Committee approval.

Aims and Objectives

To study the socio-demographic characteristics and clinical variables in patients with acute and transient psychotic disorders.

To study the role of stressors in causation and phenomenology in patients with acute and transient psychotic disorders.

Materials and Methods

It was a cross sectional observational study. The sample was obtained from the patients attending the out-patient and in-patient unit of the Department of Psychiatry in one of the tertiary care hospital, located in Northern India from January 2019 to December 2019. One hundred and Fifty patients fulfilling the inclusion criteria were included in the study.

Inclusion Criteria:

1. Patients fulfilling ICD-10 diagnostic criteria for Acute and transient psychotic disorder.
2. Patients falling in the age range of 15-60 years.
3. Patients of either sex.

Exclusion Criteria:

1. Patients suffering from organic disorders of any aetiology, including psychoactive substance induced disorders.
2. Patients having co-morbid psychiatric disorders.
3. Patients having mental retardation.

Instruments and Tools: A written informed consent was obtained from the patients and/or their family members. Socio-demographic profiles of the patients were recorded on a self-designed, semi-structured proforma and Modified Kuppaswamy Scale was used to determine socioeconomic status.[10] A self-devised clinical profile sheet was used to record history and clinical information obtained from the patients and their family members. Therefore, PSLES and PANSS were applied to identify the stressors and to measure the phenomenology of these patients respectively.

PSLES (Presumptive Stressful Life Event Scale): A simple scale to administer stressful life events based

upon open ended questions along with Holme's and Rahe's Social Readjustment Rating Schedule, constructed and standardized was used. This scale having 51 items or types of stressful events. The scale items are further divided into desirable, undesirable and ambiguous and also into personal and impersonal categories. Statistically significant differences is observed between the desirable and undesirable items, the latter being perceived as more stressful.[11]

PANSS (Positive and Negative Syndrome Scale): Scale was developed by Kay, Fiszbein, and Opler et al (1987). The PANSS has 3 subclasses - 7 items for positive symptoms, 7 items for negative symptoms and 16 items for general psychopathology (Total 30 Items). These items are rated after a semi-structured interview with patient and available information from relatives, staff and others.[12]

Statistical analysis: Descriptive data on socio demographic and clinical variables were analyzed by using percentage, mean and standard deviation. Data was analyzed using latest version of statistical software SPSS Info.

Results

Socio-demographic profile: A total of 150 patients were diagnosed with ATPD during this study period. Overall, 51% were female and 49% were male. Around 95 (63%) patients were between 15-35 years of age with a mean age of 32.45 ± 11.25 years. Majority of the patients were educated above matriculation (72%) and only 2%

patients were without any formal education. More than half of the patients were married (55%) and unemployed including the housewives (33%) and students (32%). A large number (78%) of the patients lived in nuclear families and 68% belonged to lower socio economic status. A bulk of 145 patients were from rural background. (Table-1)

Clinical variables: Most of the patients (82%) had acute onset and only few (18%) had an abrupt onset. Out of the 150 patients, 63 (42%) presented within one week, 50 (33.33%) presented within 1-2 weeks and 37 (24.66%) presented within 2-3 weeks of the onset for psychiatric consultation. Majority did not have past and family history of psychiatric illnesses. Only 18 patients had past history and 5 patients had family history of psychiatric illness

Stressors: About 75% (113) patients had stressors on PSLES preceding the onset of illness. 37 patients had no stressful life events. Out of the remaining 113 patients, 42 had one stressor (PSLES 1), 48 had two stressors (PSLES 2) and 23 had three or more stressors (PSLES 3) during the year prior to the onset of illness. On the average value of PSLES (Table-2), PSLES 1 score was very high compared to the average value of PSLES 2 and PSLES 3 score. Patients showed stress only in 19 areas out of 51 areas on PSLES. The most frequent area of stress was self or family member unemployment (19.70%) followed by failure in examination or interview (13.30%) as showed in Table-3.

Table 1: Sociodemographic profile

Socio demographic profile		No. of Patients(percentage)	95 % CI(Confidence Interval)
AGE (in years)	15-25	55 (36.67 %)	24.59-50.10%
	26-35	40 (26.67 %)	16.07-39.66%
	36-45	32 (21.33 %)	12.07-34.20%
	46-60	23 (15.33 %)	7.10-26.57%
Sex	Male	73 (48.67 %)	35.23-61.61%
	Female	77 (51.33 %)	38.39-64.77%
Locality	Rural	145 (96.67 %)	88.47-99.59%
	Urban	5 (3.33 %)	0.41-11.53%
Education	No Formal Schooling	3 (2 %)	0.04-8.94%
	Up to Primary	10 (6.67 %)	1.85-16.20%
	Up to Middle	28 (18.67 %)	9.52-30.44%

	Up to Matriculation	50 (33.33 %)	21.69-46.69%
	Up to Senior Secondary	48 (32 %)	20.26-44.96%
	Up to Graduation or Higher	11 (7.33 %)	2.76-18.39%
Occupation	Unemployed / Student	47 (31.67 %)	20.26-44.96%
	Labourer	5 (3.33 %)	0.41-11.53%
	Self Employed	10 (15.00 %)	7.10-26.57%
	Government Job	23 (6.67 %)	1.85-16.20%
	Farmer	15 (10.00 %)	3.76-20.51%
	Housewife	50 (33.33 %)	21.69-46.69%
Family Structure	Joint	33 (22 %)	12.07-34.20%
	Nuclear	80 (53.33 %)	40.00-66.33%
	Extended Nuclear	37 (24.67 %)	14.72-37.86%
Marital status	Married	83 (55.33%)	41.61-67.88%
	Unmarried	62 (41.34%)	29.07-55.12%
	Divorced / Widowed	5 (3.33%)	0.41-11.53%
Socioeconomic status (Kuppuswamy's scale)	Upper	-	-
	Upper middle	8 (5.33 %)	1.04-13.92%
	Lower middle	40 (26.67 %)	16.07-39.66%
	Upper lower	90 (60.00 %)	46.54-72.44%
	Lower	12 (8 %)	2.76-18.39%

Sociodemographic characteristics (no of patients with their percentage and confidence interval) diagnosed with acute and transient psychotic disorder.

Table 2: Scores on PSLES.

Sr. No.	Scores	Mean \pm SD
1	Stress Scores 1 on PSLES	41.78 \pm 25.31
2	Stress Scores 2 on PSLES	22.23 \pm 24.55
3	Stress Scores 3 on PSLES	6.83 \pm 16.49

Mean scores and standard deviation (SD) on Presumptive Stressful Life Events Scale of the patients with acute and transient psychotic disorder .

Table 3 : Stressful areas on PSLES.

Sr. No.	Area in which Stress was experienced	Frequency	Percentage
1	Self or Family Member Unemployed	40	19.70%
2	Failure in Examination/ Appearing for an Examination or Interview	27	13.30%
3	Financial Loss or Problems	25	12.31%
4	Illness of Family Member/ Trouble at Work with Colleagues, Superiors or Subordinates	22	10.83%
5	Family Conflict/ Break-up with Friend	17	8.37%
6	Major Personal Illness or Injury	12	5.91%
7	Death of Close Family Member	10	4.92%
8	Detention in Jail of Self or Close Family Member	7	3.45%
9	Trouble with Neighbour/ Unfulfilled Commitments	5	2.46%
10	Begin or End Schooling	5	2.46%
11	Marital Conflict	5	2.46%
12	Excessive Alcohol or Drug use by Family Member	5	2.46%
13	Broken Engagements of Love affairs	5	2.46%
14	Marriage of Daughter or Dependent Sister	3	1.47%
15	Major Purchase or Construction of the House	3	1.47%
16	Marital Separation/ Divorce	3	1.47%
17	Lack of Child	3	1.47%
18	Son or Daughter Leaving Home	3	1.47%
19	Birth of Daughter/ Gain of New Family Member	3	1.47%

Frequency and percentage of acute and transient psychotic disorder patients having stressful life events on Presumptive Stressful Life Event Scale.

Phenomenology: The average value of PANSS scores was 75.68 ± 10.48 . The average PANSS score was higher for female patients (76.81 ± 9.94) than male patients (74.48 ± 11.08). The most commonly observed symptom was lack of judgement and insight in 100% patients followed by poor attention and difficulty in

abstract thinking in 98% patients. Psychotic symptoms like delusions, hallucinations and unusual thought content were observed in around 98%, 95% and 57% of the ATPD patients respectively. Affective symptoms such as anxiety in 45% and depression in 32% patients were also identified. All the observed phenomenology in ATPD patients is described in Table 4, 5 and 6.

Table 4: Positive Phenomenology in ATPD patients

Sr. No.	Symptomatology	Frequency	Percentage	95% CI
1	Suspiciousness / Delusion	147	98.00%	91.06-99.96%
2	Hallucinatory Behaviour	143	95.33%	86.08-98.96%
3	Hostility	105	70.00%	56.79-81.15%
4	Excitement	93	62.00%	48.21-73.93%
5	Conceptual Disorganization	50	33.33%	21.69-46.69%
6	Grandiosity	22	14.66%	7.10-26.57%

Frequency, percentage and confidence interval (CI) of the positive symptoms of PANSS in patients with ATPD.

Table 5: Negative Phenomenology in ATPD patients.

Sr. No.	Symptomatology	Frequency	Percentage	95% CI
1	Poor Rapport	123	82.00%	69.56-90.48%
2	Difficulty in Abstract Thinking	110	73.33%	60.34-83.93%
3	Social Withdrawal	95	63.33%	49.90-75.41%
4	Emotional Withdrawal	87	58.00%	44.88-70.93%
5	Blunted Affect	77	51.33%	38.39-64.77%
6	Lack of Spontaneity and Flow of Conversation	63	42.00%	29.07-55.12%
7	Stereotyped Thinking	13	8.67 %	2.76-18.39%

Frequency, percentage and confidence interval (CI) of the negative symptoms of PANSS in patients with ATPD.

Table 6: General psychopathology in ATPD patients.

Sr. No.	Symptoms	Frequency	Percentage	95% CI
1	Lack of Judgement and Insight	150	100.00%	94.04-100.00%
2	Poor attention	147	98.00%	91.06-99.96%
3	Uncooperativeness	123	82.00%	69.56-90.48%
4	Poor impulse Control	88	58.67%	44.88-70.93%
5	Unusual Thought Content	85	56.67%	43.24-69.41%
6	Tension	68	45.33%	32.12-58.39%
7	Anxiety	68	45.33%	32.12-58.39%
8	Motor Retardation	68	45.33%	32.12-58.39%
9	Active Social Avoidance	55	36.67%	24.59-50.10%
10	Depressed Mood	48	32.00%	20.26-44.96%
11	Somatic concern	35	23.33%	13.38-36.04%
12	Preoccupation	30	20.00%	10.78-32.33%
13	Disturbance of Volition	23	15.33%	7.10-26.57%
14	Guilt Feeling	17	11.33%	4.82-22.57%
15	Mannerism and Posturing	13	8.66%	2.76-18.39%
16	Disorientation	2	1.33%	0.04-8.94%

Frequency, percentage and confidence interval (CI) of the general psychopathology of PANSS in patients with ATPD

Discussion

Socio-demographic variables :The most common age group was 15-35 years in our study where around 63% of the patients were diagnosed with ATPDs which is almost similar to previous studies done by Shaltout et al [13] and Lamba R et al [14] , in which 44-58% of the patients were below 35 years of age. This implies

that younger people are more vulnerable to the onset of this illness. The mean age at onset of illness in our study was higher (around 32 years) than the study done by Lamba R et al.[14] Acharya et al also reported that mean age at onset was higher. [15] In our study, ATPDs were equally distributed, with relative female preponderance (51%) i.e., females are slightly more vulnerable to the psychiatric illnesses in the long term which has also been observed by several other studies.[16,17] Although a study by Singh et al in

Nottingham found ATPDs to be more common in male than female (1.87:1). [18] Analysis of educational status of ATPD patients showed that 73% were educated beyond matriculation and it might be inferred that the highly educated people are more vulnerable to ATPDs, findings similar to a study done by Lamba R et al.[14] Other studies found that most of the patients were illiterate or had lower education.[17] Majority (65%) were unemployed including housewives and students which is almost similar to studies done by Lamba R et al.[14] Most of the patients (55%) were married in our study reflecting good social support for these patients. Studies done in last decade showed the same pattern of marital status in the patients diagnosed with ATPDs.[14,19] Regarding family type, 78 % patients were from nuclear families and 22% from joint families. Lamba R et al [14] and Ranjan et al [19] also found that most of the patients belonged to nuclear families (64% and 56% respectively). More than half of the patients (68%) belonged to lower socio-economic status. None of the patients belonged to upper socioeconomic status which might be due to the reason that people from this class might be visiting higher institutions or private hospitals for treatment. Economic hardship might increase the vulnerability of precipitating the ATPD in people with lower and middle socioeconomic status. This finding was almost similar to previous studies.[16,17] Occurrence of ATPDs was more common in people living in rural areas in our study, similar to that observed by many Indian studies. [16,17] Verma et al reported equal distribution in urban and rural background which is in contrast to our findings.[20] Higher representation of rural population in our study might be due to the fact that a substantial number of patients have been referred from rural peripheral health centre to the tertiary care centre, and due to the high (90%) distribution of population in the villages of the Northern India. Locality might not have triggered the ATPDs occurrence as the number of patients from urban areas was very small in our study for correct conclusion.

Clinical variables: Regarding the onset of illness, similar results like our study were observed in other studies by Lamba R et al [14] where majority of the patients (82%) had an acute onset and only 18 % had an abrupt onset. Analysis of duration of illness showed that 75% patients presented within 2 weeks of the onset of illness for psychiatric consultation but around 25% patients presented after 2 weeks, because in India most of the times, they are used to approach the faith-healers

in first episode of psychosis. Almost similar results were reported by other studies done in India in which the maximum number of patients presented within 2 weeks of illness.[14,20] Only 3.33% patients had family history and 11.67% patients had past history of psychiatric illness which is in sharp contrast to a study in which family and past history of psychiatric illness was found in large proportion of the patients.[20] However, some studies found no family history of psychiatric illness in these patients.[14] Family and past history in the patients determine the inherent vulnerability of an individual to the psychiatric disorders but in our study family history did not correlate significantly with ATPD.

Association of ATPD with stressful life events: In our study, it was noted that 75% patients had stressors preceding the onset of illness. Out of them, 28.33% patients had one stressor, 31.67% had 2 stressors and 15% had ≥ 3 stressors in the year prior to the onset of the illness. Verma AK et al found that the stressors were noted in upto 50% of the patients.[20] This supports the presence of stressor/s as one of the specifiers in the diagnosis of ATPD as per ICD-10. It might be inferred that psychological stressors are more important pathophysiological triggering events in the development of ATPDs than is generally recognized. It also appeared that excessive stress depleted the defensive or coping resources of a person which breaks down the psychic equilibrium and leads to the development of psychotic disorders acutely. Our study detected differences in frequencies of different types of stressors preceding ATPD. Out of the total 203 stressors in 150 patients, 19.70 % were in the form of self or family member unemployment followed by 13.30 % in the form of failure in examination or interview, 12.31 % including financial loss or problems which were comparable with a previous study done by Lamba R et al.[14] In last few years, studies found that the more common stressor was self or family member unemployment because unemployment rate had increased in these years. [20,21] Few of the uncontrollable and undesirable events like death/injury of close family members and marital conflicts were also associated with greater psychological distress which may lead to development of psychotic state. Hence, consideration of data in the present study throws light on the triggering role of different types of stressors in the causation of ATPD.

Phenomenology: The most frequent symptoms were reduced sleep and decreased appetite in all patients. As per PANSS in our study, distribution of positive

symptoms (Table 4) revealed that delusions and hallucinations were found in more than 95% of the patients which is similar to other studies that observed that all of their patients had delusions and hallucinations.[19,22,23] Delusions of persecution and reference were the most commonly observed delusions initially as in other studies.[19,22] But patients also showed other delusions, such as in the form of grandiosity (22%).which explained the rapidly changing pattern or topics of the delusions. Surprisingly unusual thought content (57%) and conceptual disorganization (33%) were present in low proportions in our study as compared to another study where they were present in more than 70% of the patients.[22] Another positive symptom, hostility was present in 70% of the patients while other studies revealed hostility as an uncommon symptom (34%) in ATPD Patients.[23] In our study, we also assessed the negative symptoms (Table-5) in different domains of PANSS i.e poor rapport and distractions in more than 70% of the patients. More than 50% patients revealed social withdrawal, emotional withdrawal and blunted affect which is highly contrasted to other studies where only 20-30% patients had negative phenomenology.[23]Both positive and negative symptoms in ATPD patients were found to be associated with greater cognitive impairment.[24] In our study most commonly observed cognitive impairments (Table 6) were lack of judgement, impaired insight, poor attention and concentration in all of the patients like other previous studies.[16,19,25] Difficulty in abstract thinking was shown by a relatively lesser number of patients (73%) as compared to study done by Kumar et al where more than 90% patients had this impairment.[16]Disturbances of affectivity were found in the ATPD patients in the forms of excitement, tension, anxiety, depressed mood, preoccupation and guilt feelings, all being present in high number of the patients at some point in time. In ATPD patients, the most common affective symptom was excitement (62%) followed by anxiety (45%) and depressed mood in 32% patients (not fulfilling the criteria of a full affective episode). In a study done by Dubey et al, excitement was present in 90% of the patients as a most common affective symptom. [23] Many studies revealed that anxiety (60-85%) was the most common affective symptom in contrast to the present study. [15,19,22] Depressive symptoms were present in a fair number of the cases in most of the studies [19,22] like our study. We assessed that the phenomenology of ATPDs patients showed a polymorphic picture with rapidly changing symptoms like changing of delusional topics,

changing of mood status and anxiety symptoms during the psychotic episodes. The present study demonstrates that polymorphous phenomenology is indeed a characteristic feature of the acute and transient psychotic disorders.

Conclusion

Most of the cases were young females and married, and the average PANSS score was higher for females. We found that a large proportion (75%) of patients in our study had experienced stressors prior to the first psychotic episode. More than 50 % patients present within two weeks of illness (acute onset) for psychiatric consultation. Family history and past history of psychiatric illness was not associated with occurrence of acute and transient psychotic disorders. The study also concludes that the stressful life events are an important factor that can facilitate development of acute psychosis. The most common phenomenology were delusions, hallucinations, hostility, social withdrawal and excitement. Most of the ATPD patients on PANSS showed cognitive impairment i.e lack of judgement and insight, poor attention and concentration, difficulty in abstract thinking, poor rapport, uncooperativeness etc.

Limitations of the study & future suggestions

We did not have any requisite corrections of p value for multiple comparisons. Our study findings could not be generalized as the sample was drawn from a single centre. Longitudinal and prospective studies should be conducted to learn the cause and effect relationship of stressful life events and positive family history of mental illness and to find out how many of them convert to schizophrenia and mood disorders or remain asymptomatic.

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