IOSR Journal of Nursing and Health Science (IOSR-JNHS)
e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 8, Issue 2 Ser. VI. (Mar. - Apr .2019), PP 01-05
www.iosrjournals.org

Acute Transient Psychotic Disorder

Mr .Prem Chander
Tutor, College of Nursing, AIIMS, Raipur , Chhattisgarh
Corresponding Author: Mr .Prem Chander

Abstract: *It is difficult to be a psychiatric patient, but a good nurse can make it less so. Confusion and fear can be overcome by knowledge and compassion, and resistance to treatment is often, although by no means always, amenable to change by intelligent persuasion. Acute and transient psychotic disorders, as defined by the ICD-10, are disorders which mainly concern females, with possible onset in all ages of adult life, but usually between the thirtieth and fiftieth year of life. Their onset is acute or even abrupt within 48 hours, but only rarely dependent on acute severe stress inspite of former assumptions. The psychiatric period is very short, with a mean of 17.5 days, in some cases even only one day. Their response to antipsychotic drugs is very good and their outcome is usually favorable in spite of the fact that they are usually recurrent. They differ from schizophrenia regarding the gender distribution, age at onset, premorbid level of functioning and social interactions. The level of post episodic functioning and outcome is more favorable in ATPD than in schizophrenia. Expert nursing assessment and intervention during the acute period is imperative and may react on the long-term outcome of these patients. The Nurse play major role in psychiatric patient in good patient outcome .*

Key Words: *acute transient psychotic disorder*

Date of Submission: 24-03-2019 Date of acceptance: 08-04-2019

I. Introduction

Acute and transient psychotic disorder (ATPD) as a descriptive entity was recognized for the first time in 1992 in the International Classification of Diseases (ICD-10), which included it under psychotic disorders (F23) as a three digit code.[1] ATPD has certain key features, such as acute onset (within 2 weeks) and rapidly changing, variable polymorphic picture, which are accepted as required criteria and stress, which is an additional criterion. Most patients experience complete recovery in 2-3 months. ICD-10 offers four specific and two non-specific subcategories of ATPD based on variability of clinical picture, presence of schizophrenic symptoms, and duration of the episode(Table 1).

Table 1. International Classification of Diseases nomenclature of acute and transient psychotic disorders

ICD-10 code	Diagnostic subcategory of ATPD (F23)	Duration, months
F23.0	Acute polymorphic psychotic disorder without symptoms of schizophrenia	<3
F23.1	Acute polymorphic psychotic disorder with symptoms of schizophrenia	<1
F23.2	Acute schizophrenia-like psychotic disorder	<1
F23.3	Other acute predominantly delusional psychotic disorders	<3
F23.8	Other acute and transient psychotic disorders	<3

Acute and transient psychotic disorder is consistently reported to occur in females between early and middle adulthood. Patients affected with ATPD do not have significant pre-morbid dysfunctions. They are more likely to experience shifting polymorphic features, *e.g*., hallucinations or delusions of different type, which usually change in either content or intensity from day to day or within the same day. As a group, ATPD has different pattern of illness risk compared to schizophrenia, and different subtypes of ATPD may be genetically heterogeneous.[7]

The concept of ATPD has been present in psychiatry clinical practice for more than twenty years. Unfortunately, it has not received much attention from researchers, especially in developing countries, even when epidemiological studies of the incidence of acute psychosis have shown that acute and transient psychosis is ten times more common in developing countries as compared to the industrialized countries. The topic has been under-researched probably because of diagnostic and classification uncertainties surrounding ATPD. The present classification of the ATPD is also cumbersome and is proving to be a barrier for research and practice. Furthermore, its diagnostic stability has been questioned by various researchers.

World Health Organization is revising the ICD-10, and with ICD-11 publication expected soon, it is prudent to review the literature pertaining to the diagnostic stability of ATPD in developing countries, since this entity entails a different epidemiology and possible clinical course in such settings. This may enable us to understand how ATPDs affect patients chronically. This may also allow us to delineate the factors predicting the diagnostic stability or diagnostic shifts, if any.

II. Case Report

A 21 -year-old male patient with uneventful birth and developmental history without past and family history of neurological and psychiatric illness presented with an illness of 1-month duration, which started with , suspiciousness, irritability, abusiveness , violent, and aggressive behavior , could not recognize mother, muttering to self. Since 13 days in onset , progressive,. there is no history of fever On examination, psychotic features like the hyperactivity, aggressiveness, muttering to self, , and decreased sleep were observed. He was hospitalized with a diagnosis of acute and transient psychotic disorder as per the International Classification of Diseases-10th Edition criteria

Temperature 98.6, vitals are pulse =98 bpm , respiratory rate 21/mts, SPO_2-98%, lung sounds bilaterally crepitus absent, S1& S2 sounds present . patient undergone various diagnostic test that mental status examination done, thyroid function test, ECG done -

blood investigation done Hb-9.8 ,TLC-13.03×10^3/µL, ,neutrophill=10.15×10^3/µL, , , Na-134.8,K- 5.2 ,Ca- 8.4 , Bilirubin-1.38 , SGOT/SGPT- 157/61 Alkaline phosphate-212 CRP-14.1 ,ESR- 26. He was started on injection lorazepam twice a day with tablet clozapine 45 mg bd for initial 6 days. He improved minimally. Injection lorazepam continued for next 3 days. . His psychotic symptoms improved significantly with the antipsychotic medicines. The mini-mental status examination for patient score varied between 24 and 27 during the course of treatment. No adverse effects of antipsychotic medicine were reported. Following resolution of psychotic symptoms parentral medicines were stopped, and he was discharged from the hospital with the advice to continue tablet clozapine 45 mg/day. After 1 month of follow-up, he was completely asymptomatic and his mini mental status examination score was 30.

Nursing assessment based on system:

1) Cardiac :

- Central pulse present
- Peripheral pulse present.
- Peripheral temperature is - 98.6 F
- urine output is 100 ml/hr

2) systolic and diastolic pressure is 120/80mmHg

3) Respiratory.

- Oxygen saturation is 98%
- Auscultated no crackles lungs sounds present

4) Neurologic

- Pupillary reflex present □
- Corneal reflex present □
- patient conscious but disoriented
- Spontaneous eye opening present

5) Gastrointestinal

- Abdominal girth normal.
- Bowel sounds present
- Nutritional assessment done

Nursing Management:

1. Nursing diagnosis: Disturbed *thought process, related to disease condition* as evidenced by delusion of persecution.

Objective: The patient will eliminate pattern of delusional thinking.

Nursing intervention:

- Assess elements of delusion without appearing to probe
- Assess the intensity, frequency, and duration of delusion
- Assess the context and environmental triggers for the delusional experience.
- Approach patient with calmness, empathy and gentle eye contact
- Communicate clearly, directly, with simple statements
- Misinterpretations of patients are clarified, arguments are avoided.
- Distract the patient from delusion that tends to exacerbate aggressive or potentially violent episodes. Promote activities that require attention to physical skills and will help the use time constructively
- Encourage the patient to express feelings as much as possible.
- Patient's participation is encouraged in providing care but not forced.
- Discourage long discussions about the irrational thinking instead talk about the real events
- Educate parents and family or significant others about the patient symptoms, the importance of medication compliance, and follow up visits

Evaluation: Patient thought process was improved

2. Nursing diagnosis: ineffective health maintenance related to inability to trust, extreme suspiciousness evidenced by poor diet intake and difficulty in falling as sleep.

Objective: patient will maintain adequate nutrition, hydration, elimination and rest and sleep.

Nursing intervention:

- Assess for malnutrition and dehydration
- Monitor food and fluid intake.
- Creative approaches should be taken with the patient, such as allowing to take packed foods, fruits, eggs etc.
- Provide less stimulating environment.
- Administer sedatives if needed.
- Prevent day time naps by involving actively in physical exercise or day treatment programs
- If the patient is suspicious or reluctant to take medications, allow the patient to open the sealed medications
- Monitor the patients elimination patterns

.

Evaluation: patient started activities of daily living and maintained elimination pattern.

3. *Nursing diagnosis: self-care deficit related to regression and cognitive impairment, evidenced by difficulty in carrying out tasks associated with hygiene*

Objective: The patient will demonstrate increased interest in self-care,

Nursing Intervention:

- Assess patient's ability to meet self care activities.
- Provide assistance with self care needs as required**.**
- Develop a structured schedule for patient routine for hygiene, toileting and meals.
- Encourage the patient to perform independently as many activities as possible.
- Praise the patient for complete activities of daily living and for initiating self care activities.
- Encourage wearing appropriate clothes
- Allow the patient enough time to complete any task
- Gradually withdraw assistance and supervise the patients grooming or other self care skills.

Evaluation: patient started completing activities with minimum assistance

4. Nursing diagnosis; potential for violence, self- directed or at others, related to command hallucinations evidenced by physical violence, destructions of objects in the environment.

Objective: the patient will not injure others or destroy property or self

Nursing Intervention:

- Maintain low level of stimulation in the patients environment
- Observe patients behavior frequently.
- Remove all dangerous objects from the patients environment
- Provide structured environment with scheduled routine activities of daily living.
- Be alert for signs of increasing agitation

- Do not use physical restraints or techniques without sufficient reason
  - Talk with the patient in a low calm voice
  - Have a sufficient staff available to indicate a show of strength to the patients if it becomes necessary
  - Administer tranquilizer as prescribed.\
  - Apply mechanical restraint safely as advised by physician. Check extremities for color, temperature, and pulse distal to the restraints for every 15 minutes.
  - Perform passive range of notion on restrained limbs and reposition the patient every two hourly.
  - As agitation subsides encourage the patient to express his feelings
  - Help the patient identify and practice ways to relieve anxiety, such as deep breathing, meditation, listening to music, etc.
  - Redirect violent behavior with physical outlets for example exercises.

Evaluation: Patient expressed decrease feeling of aggression.

5. Nursing diagnosis: risk for self inflicted or life-threatening injury related to command hallucinations evidenced by suicidal ideas

Objective: patient will not harm self

Nursing Intervention:

- .Assess the nature and severity of hallucination by asking the patient to describe.
- Create a safe environment for the patient, remove all potentially harmful objects from patients' vicinity
- Ask the patient directly about the harmful intention
- Keep the patient near the nursing station
- Do not allow the patient to put the bolt on his side of the door of bathroom or toilet.

Evaluation: Patients feeling of self harm is decreased as evidenced by verbalization to deal the harmful thoughts

6) Nursing Diagnosis disturbed sensory perceptions related to disease condition as evidenced by auditory hallucination

Objective: Patient will demonstrate decrease hallucination

Nursing Intervention

- Show acceptance and use active listening skills.
- Assess for type of hallucination and characteristics of hallucination
- Ask what voice saying and where voice is it. Avoid further discussion of hallucination to prevent reinforcing inappropriate behavior
- Observe the patient for hallucinating behavior, like talking to self, stopping in mid sentence
- Interrupt hallucination by calling patient by name
- Help the patient to learn that he can dismiss hallucination by humming whistling or saying "go away" or be "quite"
- Provide busy schedule activity to prevent being all alone.
- Listen actively to the patient's family/significant others, allowing them to express fears and anxieties about mental illness, giving them support and empathy and emphasizing patient's strengths
- Educate the patient and family about the symptoms, the importance of medication compliance
- Evaluation: Decreased hallucination as evidenced by verbalization of plans to deal with hallucinations, if they occur.

7) Nursing Diagnosis: social isolation related to an inability to trust others as evidenced by sad, dull affect with own thoughts,

Objective: To help the client to develop and use social skills and an effective social system

Nursing Intervention

- Convey an accepting attitude by making brief frequent contacts.
- Show unconditional positive regards
- Give recognition and positive reinforcement for the patient's voluntary interaction with others
- Encourage the patient to talk about feelings and do not expect immediate trust
- .Encourage the client to reveal delusion without engaging in prove a struggle over their content
- .Teach the family ways to cope with client's delusional thinking
- Facilitate trust and understanding by maintaining staff assignments as consistently as possible

- Anticipate and fulfill patients needs until functional communication pattern returns.

Evaluation: Patient started taking part in group activities.

References

[1]. R.Sreevani, Mental Health and Psychiatric Nursing , 4th Edition , Jaypee Publications , Page No 186,187,171,172.
[2]. Jorgensen P, Bennedsen B, Christensen J, Hyllested A. Acute and transient psychotic disorder: comorbidity with personality disorder. *Acta Psychiatr Scand*. 1996 Dec. 94(6):460-4. 9(medline)
[3]. World Health Organization. The ICD-10 classification of mental and behavioral disorders. Geneva: World Health Organization; 1992.
[4]. 5. Mehta S, Tyagi A, Swami MK, et al. Onset of acute and transient psychotic disorder in India: a study of sociodemographics and factors affecting its outcome. East Asian Arch Psychiatry 2014; 24:75-80. [PubMed]
[5]. Farooq S. Is acute and transient psychotic disorder [ATPD] mini schizophrenia? The evidence from phenomenology and epidemiology. Psychiatr Danub 2012;24:311-5. [PubMed]
[6]. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association; 2013.
[7]. Susser E, Fennig S, Jandorf L, Amador X, Bromet E. Epidemiology, diagnosis, and course of brief psychoses. *Am J Psychiatry*. 1995 Dec. 152(12):1743-8**. [**Medline].
[8]. American Psychiatric Association (1994) (1994) Diagnostic Diagnostic and Statistical Manual of Mental Disorders and Statistical Manualof Mental Disorders ((44tthheeddnn)) (DSM^IV).Washington,DC: APA.

Mr .Prem Chander. "Acute Transient Psychotic Disorder." IOSR Journal of Nursing and Health Science (IOSR-JNHS), vol. 8, no. 02 , 2019, pp. 01-05.