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Recurrent acute and transient psychotic disorder: A pilot study

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ABSTRACT

Acute and transient psychotic disorder (ATPD) is associated with recurrent episodes of illness in 35–45% of cases. However, the course of such relapses and the factors associated with them are unclear. 20 patients with an ICD-10 diagnosis of ATPD (F23.x) who had experienced at least two episodes of illness, and who had been followed up for at least one year, were interviewed and their case records were reviewed. Information pertaining to relapses, their frequency, and the factors associated with them were collected and analyzed. The mean episode frequency was 0.7 episodes per year. Relapse within two years of the first episode ($p = 0.001$) and a later age at onset ($p = 0.016$) were significantly associated with a higher frequency of episodes. Relapse rates were 30% after a second episode and 50% after a third; mean inter-episode intervals decreased with the number of episodes, but not significantly. Patients with a stress-related onset of ATPD tended to have further stress-related relapses. Diagnostic subtypes of ATPD tended to remain stable over time. Though acute and transient psychotic disorder is a recurrent condition, recurrences do not increase significantly over time, and there is no clear evidence for a shortening of the inter-episode period. A later onset of ATPD may be associated with greater illness severity. These results are preliminary and require replication in larger prospective samples.

1. Introduction

Acute and transient psychotic disorder (ATPD) is a psychiatric disorder characterized by an abrupt or acute onset of psychotic symptoms, usually lasting less than 3 months. Though this condition is generally associated with full recovery and good outcomes, recurrences occur in a substantial number of patients (Marneros, 2006).

The analysis of these recurrences is complicated by the fact that some patients with an index diagnosis of ATPD are later diagnosed with another psychiatric condition, such as bipolar disorder or schizophrenia. This was illustrated by a study of 32 patients with ATPD, followed up over three years. Though the crude rate of relapse was high (21/32, 65.6%), when patients with diagnostic changes were excluded, only 4 of 11 patients (36.3%) with "true" ATPD had more than one episode (Singh et al., 2004). Similarly, a follow-up study of ATPD over 3–7 years found that 58% of patients relapsed; however, 12% of these relapses were associated with significant impairment and a poor functional outcome, suggesting a diagnosis of schizophrenia; thus, the "true" relapse ATPD rate was 46% (Jager et al., 2003). Data from Iran (Alaghband-Rad et al., 2006) and India (Malhotra, 2007) is consistent with these observations, with recurrence rates of 26.7% at 2 years, 35% at 5 years and 46.8% at 8 years being reported for "true" ATPD. A study of American patients with non-affective acute remittent psychosis found that of 11 patients followed up at four years, 6 (54.5%) had only a single episode and full remission over the entire study period; the remaining 5 (45.5%) had recurrent episodes with complete inter-episode recovery (Mojtabai et al., 2003).

Though ATPD shares certain clinical features – such as an episodic course and good inter-episode recovery – with bipolar disorder, clinical research suggests that the two conditions are distinct (Marneros et al., 2002). Little work exists comparing the long-term course of these two conditions. While bipolar disorder has been associated with more frequent episodes and a shortened inter-episode interval over time (Angst and Sellaro, 2000), this has not been demonstrated in ATPD. A 2–3 year follow-up study found that ATPD was associated with more relapses per unit time than schizoaffective bipolar disorder, but this difference was significant only at a trend level. Overall functioning was significantly better, and disability significantly less, in patients with ATPD (Marneros et al., 2002). These findings suggest that the course and outcome of this condition is generally benign.

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In order to conduct a preliminary investigation of the course of this disorder and the factors affecting it, we assessed 20 patients with a verified ICD-10 diagnosis of ATPD who had experienced more than one episode.

2. Methods

Patients with a stable diagnosis of ATPD, following up at the psychotic disorders out-patient clinic of our institute in the period March–August 2014, were approached for participation in the study, and those who consented were included. A total of 31 patients were screened during this period, of whom 20 were included; of the remaining 11, 7 patients had only a single episode, two were re-diagnosed as having schizophrenia at the time of assessment, one had comorbid mild mental retardation, and one was unwilling to participate in the study. This research was approved by the Institute's Review Board.

Demographic details of all the study subjects – age, sex, occupation, years of education and marital status – were recorded based on patients' and caregivers' reports and supporting documents, such as ration cards and medical records. Information regarding the age at onset of illness, duration of the index episode, episode number and frequency, comorbid substance use and premorbid personality was obtained by interviewing patients and their caregivers, and was supplemented by consulting patients' medical records; no structured instrument was used for the diagnosis of comorbid disorders. Information regarding family histories of mental illness was collected in a similar way. Current levels of functioning were assessed by self-report from patients and caregivers.

As the duration of follow-up varied across patients, an index of number of episodes/years of illness was calculated as a rough measure of episode frequency, as was done in an earlier study (Marneros et al., 2002). The associations between episode number, episode frequency, inter-episode intervals and the various clinical and demographic variables were examined. Time intervals between episodes were estimated from case records. All statistical tests were two-tailed, and a value of $p < 0.05$ was considered statistically significant.

3. Results

A total of 20 patients – 12 women and 8 men – were included in the final analysis. The mean age of these patients at assessment was 36.4 years (range 18–56 years). They had been educated for an average of 10.25 years (range 5–16 years). 14 of them were married, and 6 were single. Women in the sample were older and more likely to be married, but these differences were not statistically significant.

Table 1
Demographic profile of patients with recurrent ATPD.

Variable	Male patients ($n=8$)	Female patients ($n=12$)	Total ($n=20$)
Age (years)	30.8 ± 8.6	40.1 ± 10.9	36.4 ± 10.9
Years of education	10.9 ± 3.2	9.8 ± 3.5	10.3 ± 3.3
Occupation (self-reported)			
Agriculture	3	1	4 (20%)
Manual labour	3	–	3 (15%)
Business	1	–	1 (5%)
Technical	–	1	1 (5%)
Student	1	–	1 (5%)
Homemaker	–	10	10 (50%)
Marital status			
Single	4	2	6 (30%)
Married	4	10	14 (70%)

Most of the men were employed as labourers or farmers, while the majority of women were homemakers (Table 1).

3.1. Illness variables

The mean age at onset of ATPD was 31.5 years (range 14–55 years). Patients had experienced an average of 2.5 episodes (range 2–4) and the total duration of their illness ranged from 1 to 14 years (mean 4.9 years). The mean duration of the index episode was 32.5 ± 19.5 days (range 7–60 days). The most frequent diagnostic subtype was "Other acute and transient psychotic disorder" (F23.8), followed by "Acute schizophrenia-like psychotic disorder" (F23.2) and "Other predominantly delusional psychotic disorder" (F23.3). Only two patients had the classical polymorphic subtype of ATPD. There were no significant gender differences on any of these parameters; however, preceding stressors were more common in women (see Section 3.4). These details, and other clinical variables of interest, are summarized in Table 2.

3.2. Course of the illness

The majority of relapses (13 of 20, 65%) occurred in the first two years after an index episode, with 10 (50%) occurring in the first year; at 10 years, all patients had experienced at least one relapse.

Patients with early relapses (within 2 years of onset) had a significantly higher number of episodes per year (mean 1.4 vs 0.3; Mann–Whitney $Z = 3.36$, $p = 0.001$), though they did not differ in terms of the absolute number of episodes.

The average episode frequency, calculated as total number of episodes divided by the total duration of illness, was 1.0 ± 0.7 episodes/year (range 0.1–2.0). There was a trend towards a higher episode frequency in men (1.4 vs 0.8 in women; $t = 1.98$, $p = 0.063$). Age of onset was positively correlated with the number of episodes per year (Pearson's $r = 0.53$, $p = 0.016$). When we divided patients into early- and late-onset groups, using a cut-off of 25 years of age, the latter group had a significantly higher number of episodes per year (1.4 vs 0.6; $t = 2.99$, $p = 0.008$). However, a multivariate analysis including all the above variables did not identify any significant predictor of episode frequency.

3.3. Diagnostic stability of subtypes

Only three patients were diagnosed as having a different subtype of ATPD in a subsequent episode; the remaining 17 retained the same subtype across episodes. Two patients had a diagnostic change from "other ATPD" (F23.8) to "acute predominantly delusional ATPD" (F23.3); the remaining patient was diagnosed as "acute polymorphic psychotic disorder with symptoms of schizophrenia" (F23.1) in the index episode and "other ATPD" in her second episode. All the patients with a diagnostic transition were women, and none of the patients with acute schizophrenia-like psychosis had a diagnostic change, but these differences were not statistically significant.

3.4. Effects of stress

Six patients reported a preceding stressor for their initial episode; all of these patients were women ($p = 0.042$, Fisher's exact test). Four of six patients with a stress-related onset had subsequent stress-related episodes, compared to none in the remaining patients ($p = 0.003$, Fisher's exact test). Reproduction-related events were the commonest stressors (childbirth in 3, failed infertility treatment in 1). Patients with a preceding stressor were more likely to have 3 or more episodes of ATPD ($p = 0.037$, Fisher's exact test), though they did not differ in terms of the