A STUDY ON ACUTE AND TRANSIENT PSYCHOTIC DISORDER- CLINICAL CHARACTERTICS AND DIAGNOSTIC STABILITY

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CERTIFICATE

THIS IS TO CERTIFY THAT THE DISSERTATION ENTITLED " A Study on Acute and Transient Psychotic Disorder- Clinical Characteristics and Diagnostic Stability" is the bonafide original work of **Dr. M. VENKAT LAKSHMI** in partial fulfillment of the requirement for M.D(psychiatry) BRANCH - XVIII Examination of the Tamilnadu Dr. MGR Medical University to be held in April 2011. The period of study was from January to October 2010.

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DECLARATION

I **DR. M. VENKAT LAKSHMI** solemnly declare that the dissertation titled, **"A Study on Acute and Transient Psychotic Disorder - Clinical Characteristics and Diagnostic Stability"** is a bonafide work done by me at Madras Medical College during 2008-2011 under the guidance and supervision of **Dr. R. SATHIANATHEN, M.D., D.P.M., M.P.H.,** Professor of Psychiatry, Madras Medical College.

The dissertation is submitted to Tamilnadu, Dr. M.G.R. Medical University, towards partial fulfillment of requirement for the award of **M.D. Degree (BRANCH - XVIII) in Psychiatry.**

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Date:

(Dr. M.VENKAT LAKSHMI)

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A STUDY ON ACUTE AND TRANSIENT PSYCHOTIC DISORDER – CLINICAL CHARACTERISTICS AND DIAGNOSTIC STABILITY

INTRODUCTION

Acute and transient psychotic disorders with good outcome are recognized in both ICD(10) (World Health Organization 1992 A)(*51*) and DSM IV(American Psychiatric Association 1994)(*2*) as distinct from schizophrenia and affective psychoses. Right from the beginning acute and transient psychotic disorder and its equivalents have occupied an ambivalent position challenging the kraeplinian dichotomy

There is a growing empirical evidence to suggest that acute brief psychoses exhibit a distinctive epidemiological characteristics (Susser, E., Wanderling, J. *45*) and benign long term course (*44*). These evidence support that the concept of ATPD as an distinct nosological entity (Mojtabai et al,*27*)

The place of non affective still remains uncertain in spite of these distinctive features.

ICD 10 came closest to the historical concepts of non affective acute remitting psychosis. But the duration criteria is so restrictive while the DSM IV classification differs from ICD 10 by not including acute onset as a criterion for classification of brief psychotic disorder and schizophreniform disorder.

The concept of ATPD and its sub categories in the current classification system (ICD 10) differs from DSM IV and is a new concept with no similar categories in DSM IV.

As there is a paucity of literature regarding the diagnostic validity and the sub classification the present study attempts to assess the diagnostic stability of acute and transient psychotic disorder and study their clinical characteristics .

REVIEW OF LITERATURE

Acute and transient psychosis as a descriptive entity was recognized only recently with the advent of ICD-10 in 1992 by WHO (51). It is included under psychotic disorder (F23). The key features that characterize the disorder are

1. An acute onset within 2 weeks.
2. Presence of typical syndromes which are described as rapidly changing, variable, polymorphic states and typical schizophrenic symptoms or predominantly delusional syndromes.
3. Being associated are not with acute psychological stress.

Complete recovery is expected in 1-3 months according to symptom durations stipulated to exclude diagnosis of schizophrenia F20 and persistent delusional disorder F22.

Acute and transient psychotic disorder of ICD 10 embraces the older concepts of German cycloid psychosis, the French concept of Bouffee Delirante and the Scandinavians (psychogenic and reactive psychosis), the Swiss emotional psychosis, the Americans remitting schizophrenia or good prognosis schizophrenia and Japanese concept of Atypical psychosis.

There is a remarkable similarity between these concepts which have influenced the world health organization category of acute and transient psychotic disorder.

NOMENCULATURE OF ATPD:

ICD 10 categories and historical concepts of acute and transient disorder.

F23	**ATPD**	**Duration (months)**	**Nosological category**
F23.0	Acute polymorphic disorder without schizophrenic symptoms	**<3**	Bouffe´e de´lirante and cycloid psychosis without schizophrenic symptoms
F23.1	Acute polymorphic disorder with schizophrenic symptoms	**<1**	Bouffe´e de´lirante and cycloid psychosis with schizophrenic symptoms
F23.2	Acute schizophrenia-like psychotic disorder	**<1**	Acute schizophrenia, brief schizophreniform psychosis, oneirophrenia, schizophrenic reaction
F23.3	Other acute predominantly delusional disorders	**<3**	Paranoid reaction, psychogenic paranoid psychosis

F23.8	Other acute and transient psychotic disorders	**<3**	**-**
F23.9	Acute and transient psychotic disorder unspecified	**<3**	Reactive psychosis unspecified

Brief views of some of the concepts that have contributed to the current classification system.

BOUFFÉE DÉLIRANTE (23, 31):

Valentin Magnan (1835–1916) and Paul-Maurice Legrain (1860–1939) in 1895 recognized it as a syndrome caused by degeneration, a 19th century concept still used by French speaking clinicians in Europe, West Africa and Caribbean.

Bouffée délirante is recognized as a psychotic disorder with acute onset without previous psychiatry history. The episode completely remits with no residual symptoms. The episodes are characterized by delusions, hallucinations, depersonalization and derealization, confusion, mood change, and changing symptoms during the course of episode.

CYCLOID PSYCHOSIS (22, 30):

The diagnosis of cycloid psychosis is still used by German, Scandinavian and European psychiatrist. Two variants of the disorder were first described by Karl Kleist (1879–1960): confusional insanity, characterized by contrasting phases of confused excitement and stupor, and motility psychosis, characterized by contrasting phases of hyper kinesis and akinesis. A third variant, anxiety-elation psychosis was introduced by Karl Leonhard (1904–1988).

Cycloid psychosis is characterized by

1. Acute onset and good prognosis with frequent recurrences.
2. Symptoms of confusion, mood-incongruent delusions, hallucinations, overwhelming anxiety, deep feelings of happiness or ecstasy, motility disturbances of akinetic or hyperkinetic type, a particular concern with death, mood swings, and rapid change occurs within an episode.

REACTIVE PSYCHOSIS OR PSYCHOGENIC PSYCHOSIS(*6*):

Karl Jaspers was the first to define this syndrome in 1913. it was also described as psychogenic psychosis by Wimmer in 1916. The diagnoses were popular among Scandinavian psychiatrist in the early part of twentieth century. It is defined as a psychotic disorder

1. With acute onset following external stress.

2. There are more affective and confusional symptoms and less bizarre symptoms.
3. Compared to schizophrenia onset is acute, occurs in late life, premorbid adjustment tends to be better and family history of schizophrenia is less likely. The prognosis is better than that of schizophrenia.

SCHIZOPHRENIFORM PSYCHOSIS (21); SCHIZOPHRENIFORM DISORDER (DSM-III):

The Norwegian psychiatrist Gabriel Langfeldt (1937–1966) introduced the concept of schizophreniform psychosis as a condition with sudden onset following an identifiable precipitating factor and with good outcome in an individual with well-adjusted premorbid personality. The patients often present with disturbance of mood and clouding of consciousness.

The term, but not the concept, was adopted by DSM-III as a psychotic syndrome with schizophrenic symptoms, which is distinguished from schizophrenia by duration of less than 6 months.

ONEIROPHRENIA (26):

Ladislas von Meduna (1896–1964) described oneirophrenia in 1939 as a syndrome characterized by acute onset of confusion, nightmare, or dream-like quality of all perceptions (hence the term “oneirophrenia”), extreme fear and anxiety, delusions, and visual hallucinations. The prognosis is generally good with full recovery. Meduna proposed an endocrinological explanation for the syndrome.

HYSTERICAL PSYCHOSIS (14):

Hollander and Hirsch described the group of disorder with sudden and dramatic onset related to a stressful event in the context of hysterical personality. The symptoms include hallucinations, delusions and depersonalization and disorganized behavior. The episode seldom lasts longer than 3 weeks.

CURRENT CLASSIFICATION

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISODERS (DSM) (2):

DSM-II (1968) was the first to recognize concept of reactive psychosis and included in category of 'other psychosis' (298), as reactive psychosis unspecified (298-9). DSM-III (1980) provided first specific operational criteria for reactive psychosis, under heading of 'brief reactive psychosis'. DSM-IIIR (1987) introduced modification in duration of symptoms, prodromal symptoms and mood alteration. DSM-IV (1994) gives 3 categories under which patients with ATPD may be classified. Brief psychotic disorder with or without marked stressor (298.8), schizophreniform disorder (295.40) and Psychotic disorder not elsewhere classified (298.9).

INTERNATIONAL STUDIES ON ATPD:

The validity of ATP came from the international initiatives in the form of WHO multi-centered collaborative studies.

1. IPSS (International Pilot-study of schizophrenia (1968-1970) (50)
2. DOSMeD (Determinants of Outcome of Severe Mental Health Disorders) (38)
3. CAP (Cross-cultural study of Acute Psychosis) (1980-1982) (9)

The findings of the three major WHO studies provided strong evidence in favor of occurrence of acute onset psychotic disorder that can be differentiated from both schizophrenia as well as MDP.

DISCUSSION ON ATPD:

IPSS - a substantial proportion (26%) of schizophrenic subjects had good outcome in the form of only one episode; and That patients from developing countries had better outcome.

DOSMED –

a. The study recognized the occurrence of non affective psychosis which remitted completely and called them as non affective, acute, remitting psychosis (NARP).

b. Incidence was 10 times higher in developing countries in the DOSMED Data.

CAP Study :

a. The main finding were large proportion (41.2 %) of acute psychosis patients showed schizophrenic symptoms, 20% showed affective symptoms and 35.3% exhibited other psychosis.

b. 41.7% showed stress close to onset.

c. Marked prevalence of patients from below-average socio-economic status.

d. 2/3 patients remained well with no relapse at 1 year.

ICMR ACUTE PSYCHOSIS STUDY (15):

A Study of phenomenology and natural history of acute psychosis was done at four centers in India (Bikaner, Goa, Patiala, Vellore) as ICMR collaborative study. It was found that 52% of cases of acute psychosis could not be categorized into any of the catego diagnosis.

CHANDIGARH CAP STUDY (47):

This was a major study of acute onset psychosis which revealed that only 60% of cases of acute psychosis fitted the criteria for diagnosis of schizophrenia and MDP as per ICD 9 and catego. 40% of cases were of non schizophrenia, non affective psychosis and could be considered as "ACUTE PSYCHOSIS"

SOCIODEMOGRAPHIC CHARACTERISTICS:

INCIDENCE AND PREVALENCE

In Scandinavian countries, reactive or psychogenic psychosis comprise of 2-10% of all psychiatric admissions and form 15-20% of all psychosis admitted (Faergeman 1963, Stromgen 1981, Allodi 1982). Castangini (8) reported the incidence of ATPD to be 9.6/1lakh population. Singh et al (46) reported the incidence rate of 3.9/1 Lakh population in Nottingham. Acute psychosis forms 10% of all psychosis(ICMR 1989 (15)).

The incidence of non-affective remitting psychosis in developing countries was 10 fold compared to incidence in industrialized country(Susser and Wanderling 45).

Acute and transient psychotic disorders, comprise 8–9% of all psychotic disorders and arguably have a benign long-term course (Pillman and Marneros et al (25)). Menon et al (37)1978 found acute psychosis forming 14.1% of cases at Institute of Mental Health and 8.93% at Government general hospital, Chennai.

AGE:

Two studies from India reported a mean age at onset of 26.9 ± 10.9 years (mean ± SD) (Sajith *et al.*, 2002 (36)) and 25 ± 9.4 years (Das *et al.*, 1999 (10)), respectively. In contrast, the patients in the Danish study of

Jorgensen and co-workers (1996 (17)) had a mean age at onset of 33 years (range 18–65 years).

ICMR (1989), Menon *et al* reported mean age of patients being less than 30 years

GENDER:

Female preponderance: ATPD is reported to be occurring more commonly among females (Susser E, Varma et al, 1995a (42), 1995 b(43), Malhotra S, Wig NN et al 1998 (24)). Female to male ratio was found to be 3.7:1 suggesting a great majority of female patient having diagnosis of ATPD. It provides evidence for the validity and delineation of ATPD from schizophrenia which is equally prevalent in both genders.(Pillman and Marneros et al 2003) (5).

Mojtabai et al(27) found acute psychosis to be twice as common in males as females. This finding of male preponderance was reported in few other studies (SWARAN P. SINGH 2004)(46)

MARITAL STATUS:

ICMR (1989), Gupta and Bharadwaj, 2000 (13), in studies on cycloid and acute psychosis found higher percentage of married individuals (approximately 70%).

EDUCATION:

In the study of Das and co-workers (1999)(10), which compared 40 patients with ATPD and 40 patients with schizophrenia more than half of the

ATPD patients (*n*=23), but only slightly more than one-third of the patients with schizophrenia (*n*=14), had education above high school level. The difference was statistically significant.

ICMR (1989) reported only 15-26% having attained educational training. Vellore centre alone reported higher educational level (48% having done high school)

SOCIO ECONOMIC STATUS AND BACKGROUND:

Majority of patients belong to low socio economic status (Jorgensen 1985(16), ICMR 1989, and Malhotra et al., 1987). Rural preponderance of ATPD cases was observed by Sajith et al 2002 and Das et al 2001.

PREDISPOSING CHARACTERISTICS:

FAMILY HISTORY:

Das et al 1999 studied 40 cases of ATPD compared with schizophrenic patients and reported that ATPD was three times more frequent in first-degree relatives of patients with ATPD than family members of schizophrenics; it was also found that first-degree relatives of patients with schizophrenia-like symptoms were more likely to develop schizophrenia than ATPD.

Marneros et al(25), reported a higher rate of mental disorders in family members of patients with ATPD than the relatives of healthy controls, but no significantly raised risk of psychotic disorders was found.

PREMORBID PERSONALITY:

Jorgensen et al (17), observed that almost 2/3rd of the ATPD patients qualified for the concomitant diagnosis of personality disorder. This rate dropped significantly 1 year later and proved that ATPD is not related to any specific disorder. Gupta and Bharadwaj (2000), reported that 17.79% to have abnormal premorbid, predominantly schizoid traits in patients with ATPD.

Singh et al and Sudha et al (41) reported that cases with ATPD do not have significant premorbid dysfunction.

PRECIPITATING FACTORS :

Varma et al (47) found that 34% of all patients experienced significant stress before the onset of illness. The study of Sajith et al. showed that life events are involved in two-thirds of cases, most often with abrupt onset (48h). Such findings compared favorably with a previous work by Okasha et al. (28) that 74% of their Egyptian patients with acute psychosis experienced some stressful event

Impersonal events were found to be higher in the six months prior to ATPD episodes, especially in the two weeks preceding the onset of their illness. Significantly more undesirable events as well as higher presumptive stress scores were also observed in the two weeks preceding the ATPD episodes. Concluding that psychological stressors and stressful life conditions have a greater triggering patho physiologic role in ATPD than in Bipolar Affective Disorder, manic phase (German J Psychiatry 2007) (34).

CLINICAL FEATURES:

SYMPTOMATOLOGY:

Marneros and Pillmal et al. 2003 reported that in 2/3rd of cases typical polymorphic symptomatology was found among ATPD patients. Among the polymorphic symptoms rapidly changing mood was more frequent followed by rapidly changing delusional topics. Anxiety, euphoric or hyperthymic were more frequently represented in ATPD group. The first rank symptoms of schizophrenia were also frequently reported in these cases.

Mojitabai et al 2003(32) reported that patients with non- affective remitting psychosis that significantly lower negative symptoms scores. ICMR reported 8 common symptoms were seen among ATPD patients such as irritability, difficulty in concentration, tension and anxiety, delusional of persecution, suspiciousness, loss of interest, early awakening and inappropriate bizarre behavior.

Okasha et al studied 50 Egyptian patients using the Schedule of Clinical Assessment of Acute Psychotic States (SCAAPS) and reported ,that the prevailing symptoms were delusions, worry, irritability, mood changes, and disturbed behavior.

DIAGNOSTIC STABILITY AND OUT COME

Diagnostic stability over a period of time is one of the ways of validating a psychiatric diagnosis(33). The more stable the diagnosis, the

more likely it is to reflect a basic and consistent psychopathological and patho physiological process.

In developing countries, ATPD has a relatively high diagnostic stability (54–73%) and low rates of relapse .Higher stability rates were found by Abe et al(1). and Suda et al.

Abe et al. [1] , reported a diagnostic stability of 63 % in a follow up period of 12 years. 30% changed to schizophrenia, 2/3 tended to recur. Suda et al. [41] on a 5 years follow up of [F23.0] reported 60 % stability. ATPD have better premorbid functioning and episodic course with longer remissions than schizophrenia

Amini et al. [3] in a 1 year study of First-episode psychosis [60] patients from Iran reported ATPD to be the most stable category.

Castagnini et al. [8] in a 6 years follow up found a stability of 39%. It is a Register-based study of first admissions representative of the Danish population. Of 416 cases followed-up 17% had mono episodic course, 22% recurrent course, 30% changed to another F2 category and 11% to affective disorder

The study of Sajith et al. [35], including a cohort of Indian patients with a first admission diagnosis of ‘acute polymorphic psychotic disorder without schizophrenic symptoms’, found that abrupt onset and brief duration (1 month) predicted diagnostic stability over 3 years and reported a stability of 73%

Marneros et al. reported 54% stability, three quarters of their cases with ATPD had a recurrent affective or psychotic episode, 30% developed affective disorders, and a relatively small number converted into either schizoaffective disorder or schizophrenia. One-third enjoyed a stable remission and discontinued medication after 7 years.

Thangadurai et al. [29] the stability was 64%, 26% converted to schizophrenia and 9% to affective disorders; 11% recurrent course

ATPD outcome better than schizophrenia (mean GAF score 70)

Okasha et al. 54% nearly 2/3 with acute psychosis had complete revision

OUTCOME BASED ON GLOBAL FUNCTIONING

Jørgensen (1995) reported a mean GAS score of 70 at the 8-year follow-up. Jørgensen and co-workers (1997) [18] reported an identical mean value of 70 for 24 ATPD patients at the 1-year follow-up. Sajith and co-workers (2002), in their study of 45 patients with Acute Polymorphic Psychotic Disorder in Pondicherry, India, reported a mean GAS score of 68.8 after 3 years and a standard deviation of 8.7.

The findings of the HASBAP clearly show that the overall functioning of the ATPD patients was significantly better than that of patients with Positive schizophrenia.

AIM

1. To study the demographic and clinical characteristics of Acute and Transient Psychotic Disorders (ATPD) defined by ICD-10, DCR (F23).
2. To assess the diagnostic stability of ATPD through a 3 month period follow-up.
3. To find the frequency of occurrence of sub categories of ATPD defined by ICD(10) DCR F(23)

HYPOTHESIS

- The diagnosis of ATPD is not stable
- There is no significant difference between ATPD and other diagnostic group in terms of socio demographic variables, Stressor, family psychopathology.
- There is no significant difference in psychopathology and other clinical variables between the diagnosis of ATPD and other diagnostic group.

MATERIALS AND METHODS

SETTING

This study was conducted at the Institute of Mental Health, Kilpauk, Chennai-10. The cases were recruited from the outpatient department, which functions all days of the week. The study was conducted from Jan. 2010 – Oct. 2010

SAMPLE

Consecutive cases attending the O.P. department of the Institute of Mental Health, with diagnosis of (F23) Acute and Transient Psychotic Disorder (ATPD) using the ICD-10, Diagnostic criteria for research (DCR) constituted the research population.

INCLUSION CRITERIA

- Age of the patient 16 - 60 yrs
- First episode of Acute psychosis
- First contact within thirty days of onset of illness.
- Satisfying ICD(10) DCR criteria for acute and transient psychotic disorder f(23)

EXCLUSION CRITERIA

- H/o of previous episode of psychotic illness.
- Psychotic disorders secondary to general medical condition and neurological disorder

- psychotic disorder in the presence of subnormal intelligence
- Gross organic brain disorder.
- delirium
- un co-operative patients
- Substance induced psychotic disorder.

DESIGN

A prospective follow-up design was employed. The investigator rated all cases with additional independent consensus diagnosis at index and follow up by consultants.

All cases participated in the study voluntarily after informed consent was obtained. Detailed physical and laboratory investigations were done for all cases.

The ethics committee and research panel of Madras Medical College approved the methodology.

SCHEMATIC REPRESENTATION OF STUDY DESIGN

Time of Assessment following 1st visit to OPD	Screening	Instruments
WITHIN 48 HRS	INDEX ASSESSMENT	ICD – 10 DCR, F23 (ATPD), SCAAPS PART A, B, C, PANSS, PSLES, GAF
1 WEEK	SECOND ASSESSMENT	SCAAPS PART C, PANSS, GAF
1 MONTH	THIRD ASSESSMENT	SCAAPS PART C, PANSS, GAF
2 MONTH	FOURTH ASSSESSMENT	SCAAPS PART C, PANSS, GAF
3 MONTH	FIFTH ASSESSMENT	SCAAPS PART C, PANSS, GAF
	ICD DIAGNOSIS AT 3 MONTHS	

INSTRUMENTS

The following instruments were used for assessment of all the cases.

1. ICD-10, DCR, F23 criteria for diagnosis.
2. Schedule for Clinical Assessment of Acute Psychotic States (SCAAPS, 1990).
3. Positive and Negative Syndrome Scale (PANSS, 1987).
4. Global Assessment of Functioning (GAF,APA,1994)
5. Presumptive Life Events Scale (Gurmeet Singh et al., 1984).

1. **The ICD-10 classification of Mental and Behavioral disorders, Diagnostic Criteria for Research (WHO, 1994)** [49]

   Disorders was coded using the general and subtype criteria for (**F23**) Acute and Transient Psychotic Disorders.

2. **Schedule for the Clinical Assessment of Acute Psychotic States (SCAAPS, Cooper et al., 1990)** [9]

This instrument was developed by WHO and used with minor modifications made by ICMR, in the collaborative study on Acute Psychosis (1981 - 1984). It is derived from the Psychiatric and Personal History Schedule (PPHS, Jablensky et al., 1982). It consists of 5 parts. Part A screening instrument, Part B has 14 items designed to elicit psychiatric history and other details and Part C Symptom checklist includes almost all the symptoms of PSE (Wing et al., 1974) under 19 subheadings. Each item on SCAAPS is identified with the

appropriate number of PSE. There were original 5 columns, which were modified to 11 columns by ICMR for assessments. Part D assessed diagnosis on ICD-9 basis and Part E evaluated treatment course and outcome. Part A, B and C was used for current study. ICD-10 DCR was used for diagnosis.

3. **Positive and Negative Syndrome Scale (PANSS, Kay et al., 1987) [20]**

This scale was developed by Kay, Fiszbein, Opler et al., (1987) combining items from Brief Psychiatric Rating Scale (BPRS, Overall and Gorham, 1962) and Psychopathology rating scale (Singh and Kay, 1985). The PANSS has 3 subscales – 7 items for positive symptoms, 7 for negative symptoms and 16 for general psychopathology. The items are rated after a semi-structured interview with patient and all available information from relatives, staff and others is taken into consideration.

4. **Global Assessment of Functioning Scale (GAF, APA 1994)(**11)

This is rated on 0-100 scale. It is used to assess global functioning considering psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. This does not include impairment in functioning due to physical or environmental limitation.

5. **Presumptive Stressful Life Events Scale (Gurmeet Singh et al., 1984)** [39]

This scale is based upon Holme's and Rahe's social readjustment rating schedule and has been standardised for Indian population. This scale has 51 items and each item has a mean stress score. The items of this scale are further subdivided into desirable, undesirable, ambiguous and personal

categories. It is administered in the form of a semi structured interview, where events are assessed as present or absent. The test retest reliability and content validity are found to be satisfactory.

SAMPLE CHARACTERISTICS (N=60)

The socio demographic characteristics at index assessment of 60 cases are shown in table A. There was predominance of females in the sample 56.7%. The male female ratio was1: 1.3 between 26 male and 34 females. Among the 60 cases 29 (48.3%) cases were unmarried, 29(48.3%) were married while two were widows (3.33%). 63.3% of the sample had only primary level of education or no education. Most of the sample belongs to the low socioeconomic status. 53.3% of cases were from rural background. And 56.7% of cases were cultivators or laborers and 25% did house hold work.

On follow up at three months 50 cases recruited at index completed the study. Among the 10 cases that dropped out from the study, most of the cases were not available after the first contact.

Table A

VARIABLES		N	%
Marital Status	Unmarried	29	48.3
	Married	29	48.3
	Others	2	3.3
Sex	Male	26	43.3
	Female	34	56.7
Background	Rural	32	53.3
	Urban	28	46.7
Education	Illiterate	6	10
	Primary	32	53.3
	Middle	10	16.7
	Secondary	2	3.3
	Graduation or training	10	16.7
Socioeconomic Status	Above average	3	5
	Average	26	43.3
	Below average	31	51.7
Occupation	Cultivators and labourers	34	56.7
	Household work	15	25
	Student	4	6.7
	Professional	1	1.7
	Unemployed	6	10

PROCEDURE:

Intake assessment was done within 48hrs following the first visit to OP department. The base line assessment was carried out by the rater and information was gathered from all possible and available sources. At baseline the clients were informed about follow up assessment. The follow up assessment was carried out at one week, one month, two month and three month. Treatment options were not controlled for and left to the choice of consultants

ANALYSIS PLAN:

Fifty cases completed the study and they were grouped based on their diagnosis into ATPD group (n = 34) and other psychosis group (n=16). Comparison between the ATPD group and other diagnostic groups on the following variables were studied to observe for differences between the above groups at baseline and follow-up.

1. Sociodemographic variables.
2. Predisposing characteristics of positive family history of mental illness.
3. Precipitating factors of psychological stressor preceding psychosis.
4. Clinical variables - index ICD-10 diagnosis, symptom pattern and severity of psychopathology and outcome.

STATISTICAL ANALYSIS:

The analysis was done using SPSS version 14. The P-value of less than 0.0.5 was considered significant result. Comparison between ATPD and other Psychosis group was done. For categorical variable Chi-square test was done. For continuous variables T-test was used.

RESULTS

TABLE 1:

Diagnosis At 3 months

DIAGNOSIS (N =50)	**N**	**%**
ATPD	34	68
Schizophrenia	3	6
unspecified non-organic psychosis	7	14
Mood Disorder	4	8
Delusional Disorder	2	4

The distribution of diagnosis of cases at 3 months as per ICD 10 criteria is shown in table 1. 68% retained the index diagnosis of ATPD. 32% changed to other Diagnostic groups according to ICD 10 at the end of 3 months follow up.

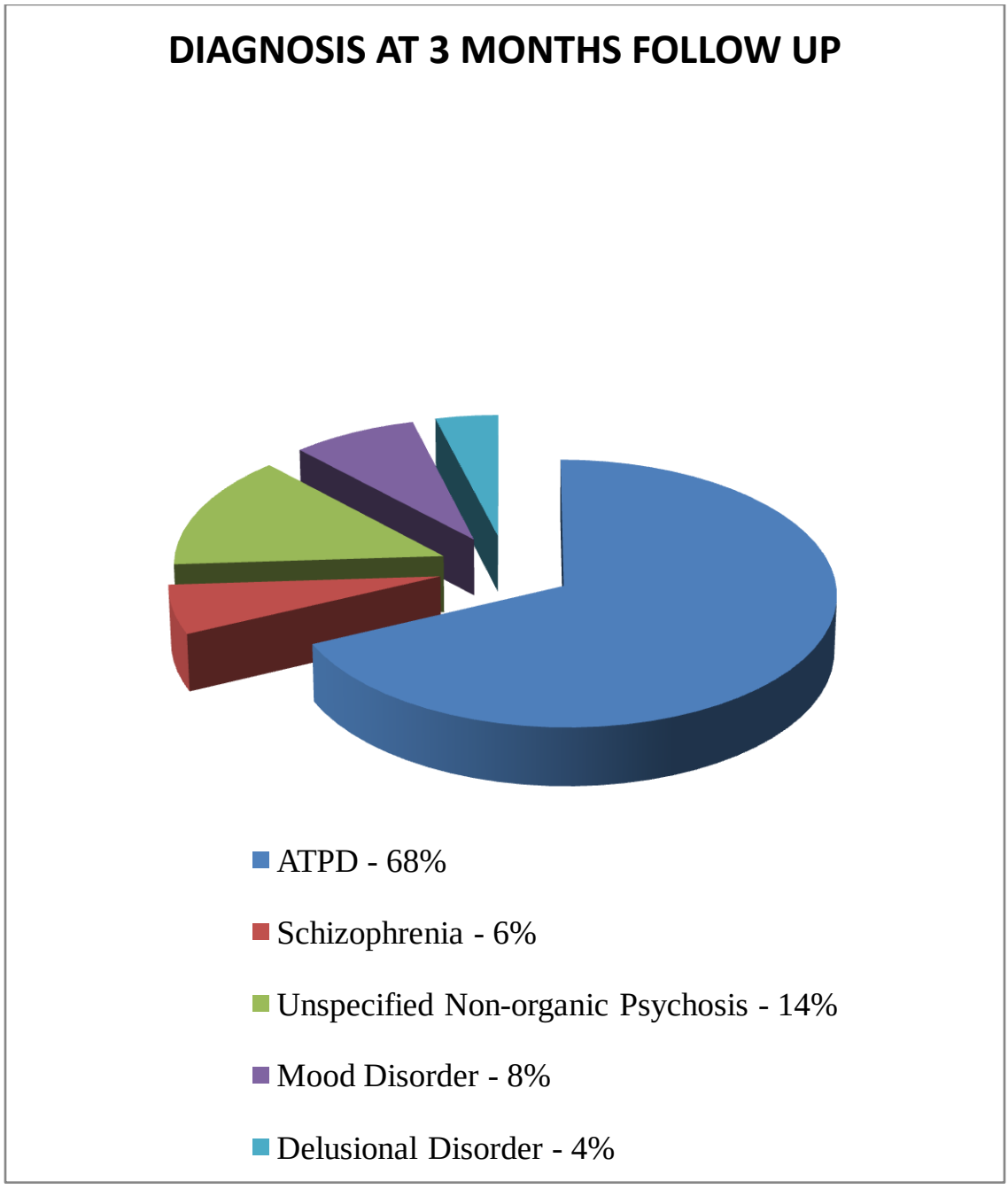
DIAGNOSIS AT 3 MONTHS FOLLOW UP
ATPD - 68%
Schizophrenia - 6%
Unspecified Non-organic Psychosis - 14%
Mood Disorder - 8%
Delusional Disorder - 4%

Fig. 1

SOCIAL DEMOGRAPHIC CHARACTERISTICS

AND DIAGNOSIS AT 3 MONTHS

TABLE 2:

Age and Diagnosis at 3 months

DIAGNOSIS	N	MEAN (YEARS)	STD. DEVIATION(YRS.)
ATPD	34	27.18	7.88
Other Psychosis	16	29.94	7.903

	VALUE	P-VALUE	SIGNIFICANCE
T-TEST	-1.155	0.254	Not Significant

Df = 48

On comparison of age between ATPD and other psychosis group, the mean age in years was found to be less for ATPD group(27.18 yrs) And the difference between the 2 groups based on age was not statistically significant (P =0.254).

TABLE 3:

Gender and Diagnosis at 3 months:

DIAGNOSIS	SEX	
	MALE	FEMALE
ATPD (n =34)	15	19
Other psychosis (n=16)	6	10
Total (n =50)	21	29

	VALUE	P-VALUE	SIGNIFICANCE
CHI-SQUARE	0.196	0.658	Not Significant

df = 1

Among patients who were diagnosed as ATPD there were more no. Of females (n=19) 55.8%. The comparison of gender between the ATPD group and other psychosis group the difference was not statistically significant (p = 0.658).

GENDER WISE COMPARISON BETWEEN ATPD AND OTHER PSYCHOSIS GROUP

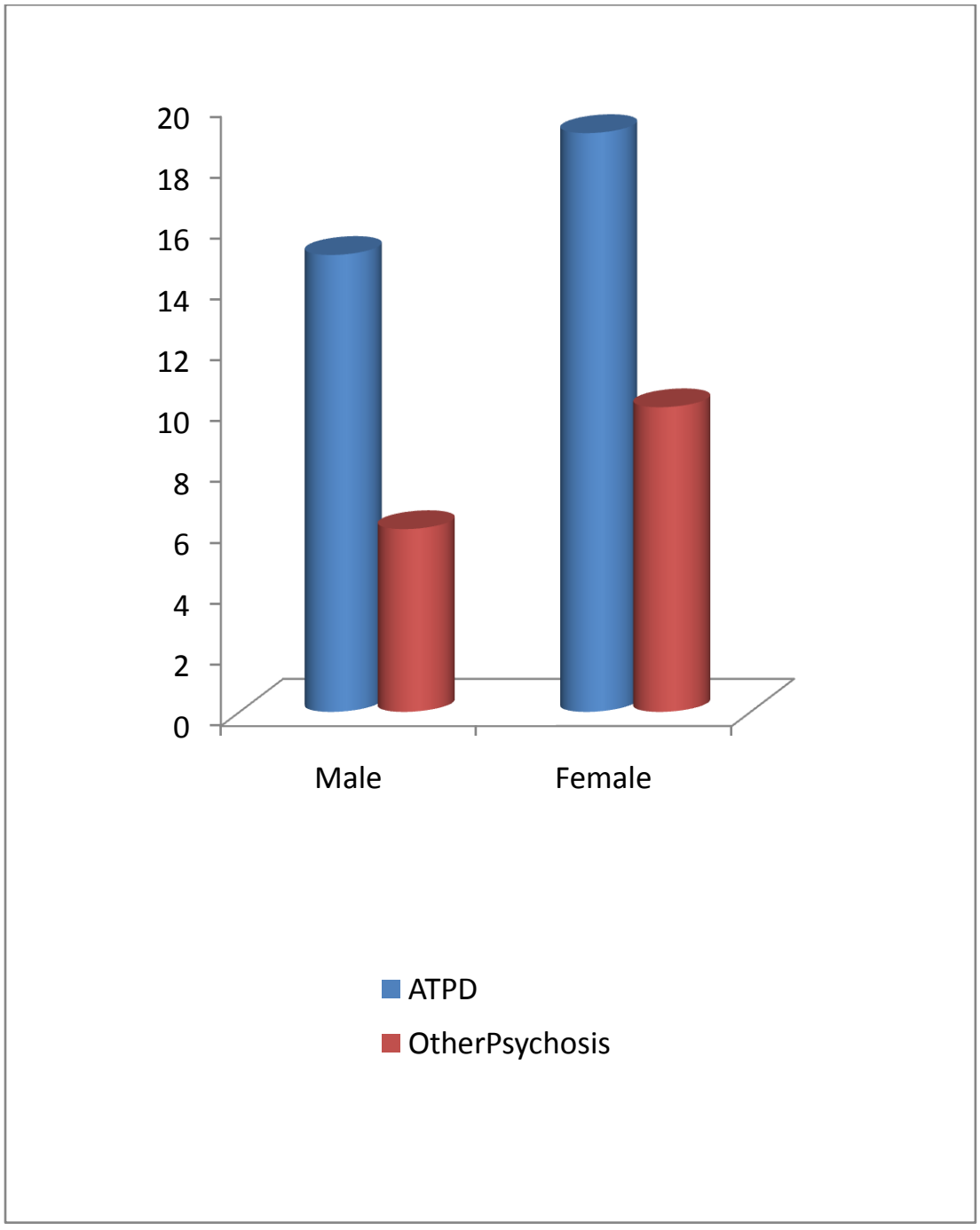

Fig. 2

TABLE 4:

Education and Diagnosis at 3 months:

DIAGNOSIS	EDUCATION			
	ILLITERATE	PRIMARY	MIDDLE	GRADUATION
ATPD (n =34)	2	20	8	4
Other psychosis (n=16)	3	10	1	2
Total (n =50)	5	30	9	6

	VALUE	P-VALUE	SIGNIFICANCE
CHI-SQUARE	3.636	0.304	Not Significant

df = 3

Based on education patients in ATPD group who had only primary level of education constituted 58.8%. The difference was not statistically significant when education was compared between the two groups (p=0.304).

COMPARISON OF EDUCATION BETWEEN ATPD AND OTHER PSYCHOSIS GROUP

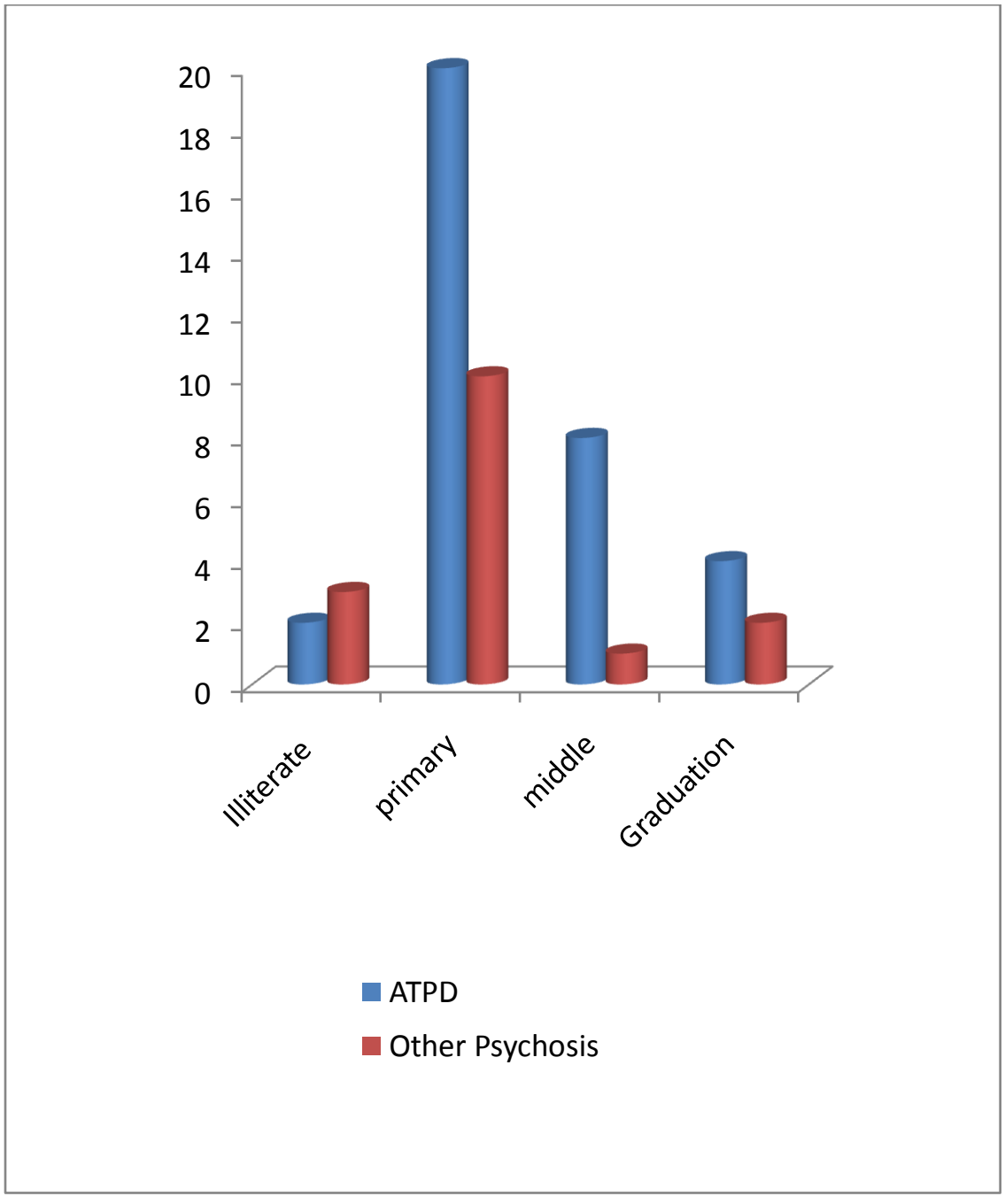

Fig. 3

TABLE 5:

Background and Diagnosis at 3 months:

DIAGNOSIS	BACKGROUND	
	RURAL	**URBAN**
ATPD (n =34)	17	17
Other psychosis (n =16)	10	6
Total (n =50)	27	23

	VALUE	P-VALUE	SIGNIFICANCE
CHI-SQUARE	0.684	0.408	Not Significant

df = 1

Among patients diagnosed as ATPD classified based on background there were equal no. of cases in both rural and urban background. The difference between the two groups was not statistically significant (P=0.408).

COMPARISON OF BACKGROUND BETWEEN ATPD AND OTHER PSYCHOSIS GROUP

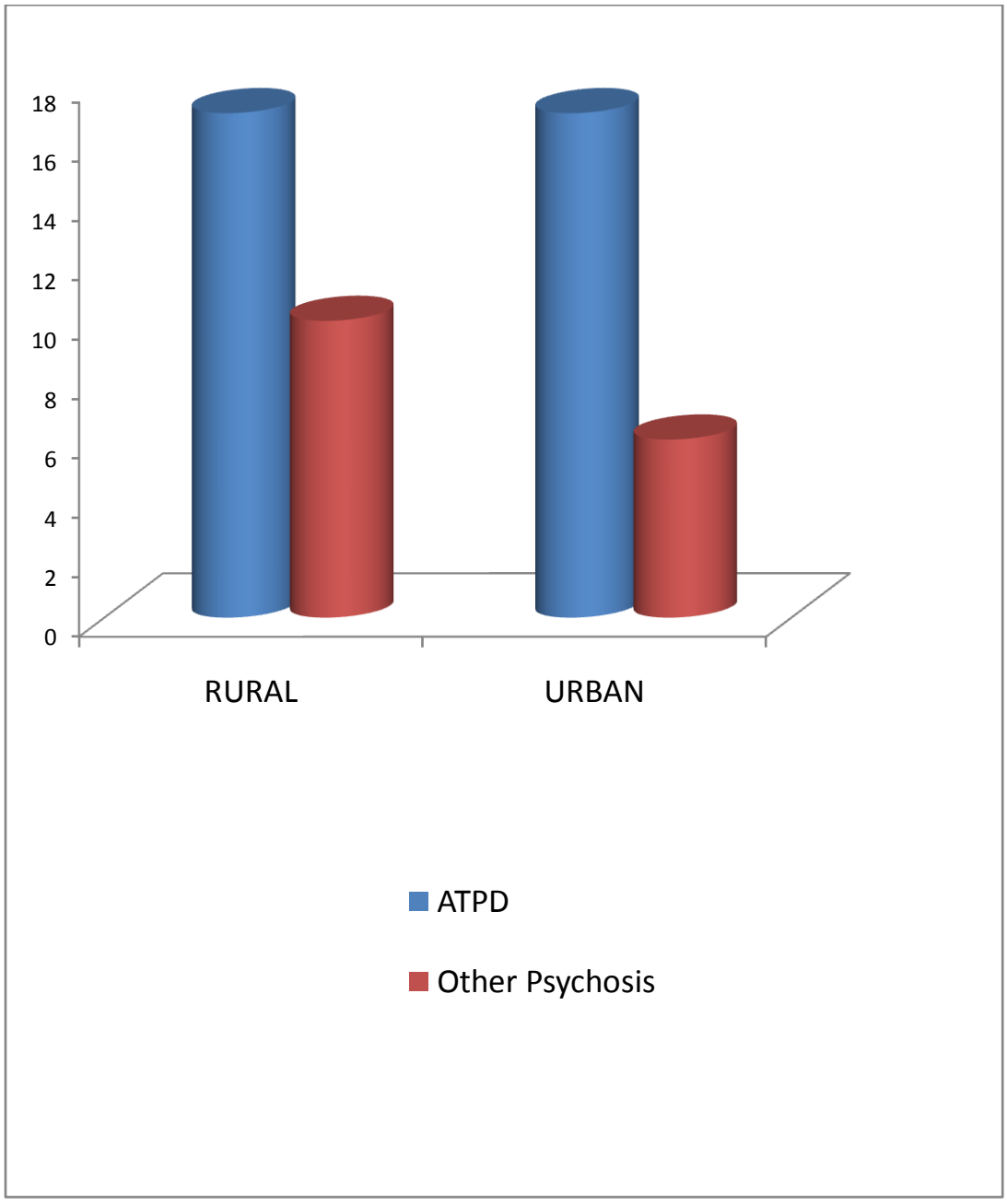

Fig. 4

TABLE 6:

Social Economic status and Diagnosis at 3 months:

DIAGNOSIS	SOCIO ECONOMIC STATUS		
	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
ATPD (n =34)	3	16	15
Other psychosis (n =16)	0	4	12
Total (n =50)	3	20	27

	VALUE	P-VALUE	SIGNIFICANCE
CHI-SQUARE	4.657	0.097	Not Significant

df = 2

91.2% of cases diagnosed as ATPD n=31 belong to low socioeconomic status. And on comparison between the ATPD and other psychosis group based on SES the difference was not statistically significant (p=0.097).

COMPARISON OF SOCIOECONOMIC STATUS BETWEEN ATPD AND OTHER PSYCHOSIS GROUP

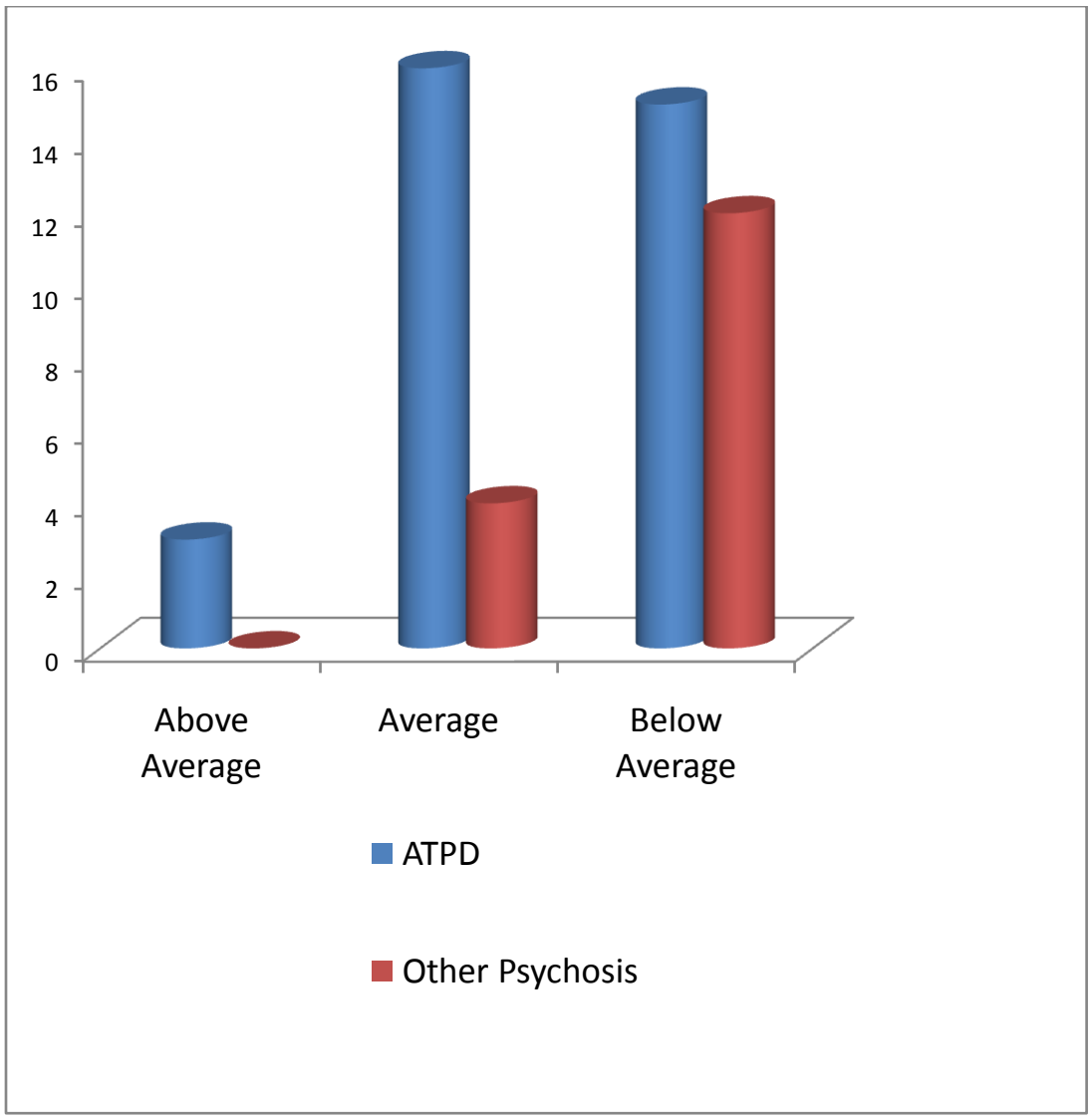

Fig. 5

TABLE 7:

Marital status and Diagnosis at 3 months:

DIAGNOSIS	MARITAL STATUS		
	UNMARRIED	**MARRIED**	**OTHERS**
ATPD (n =34)	18	15	1
Other psychosis (n =16)	6	9	1
Total (n =50)	24	24	2

	VALUE	**P-VALUE**	**SIGNIFICANCE**
CHI-SQUARE	1.172	0 .557	Not Significant

df = 2

They were more no. of unmarried people constituting about 53% in ATPD diagnosis group. When compared with other diagnostic group on marital status the difference was not statistically significant (p=0.557).

COMPARISON OF MARITAL STATUS BETWEEN ATPD AND OTHER PSYCHOSIS GROUP

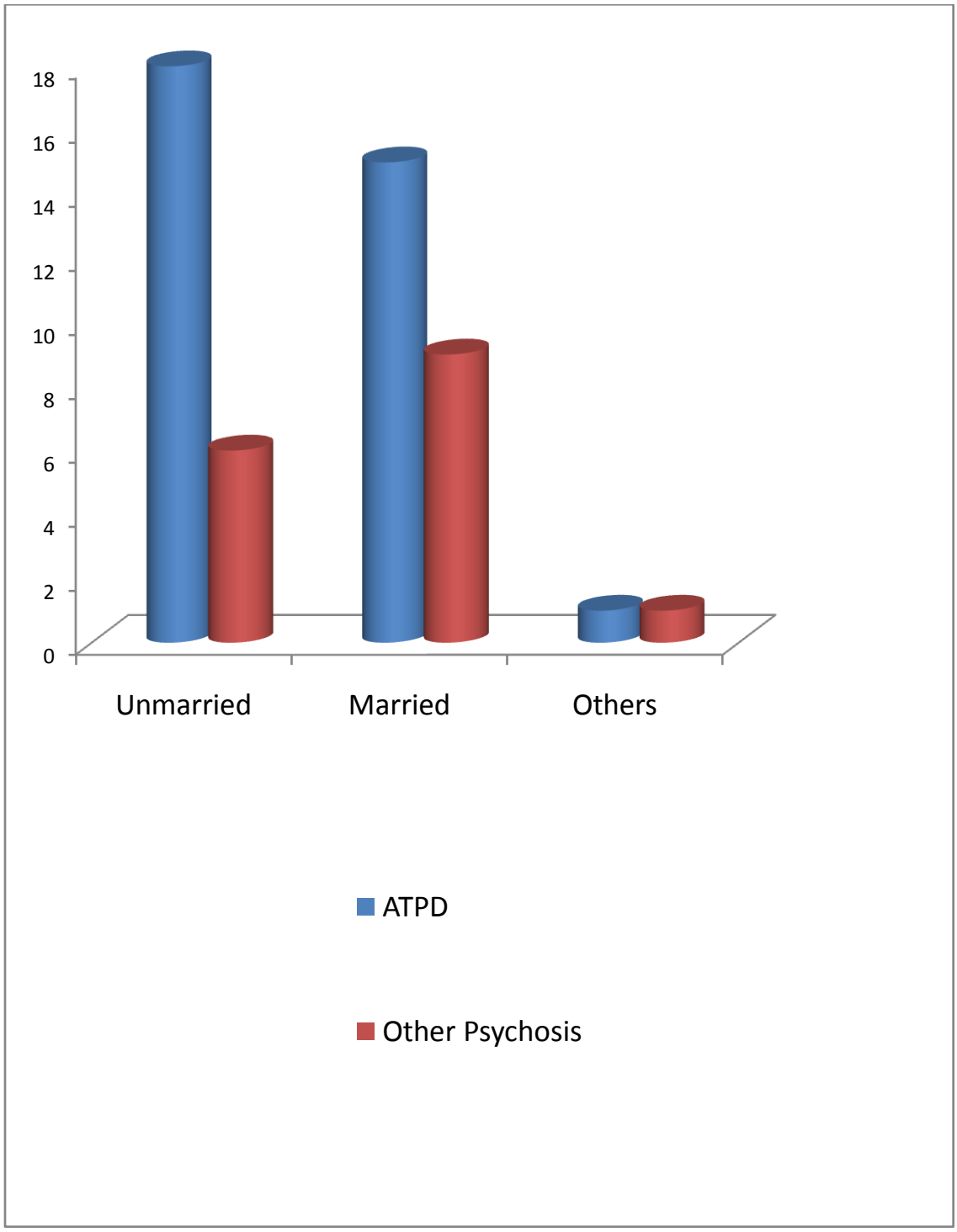

Fig.6

TABLE 8:

Occupation and Diagnosis at 3 months:

Diagnosis	Occupation				
	Cultivator	**House hold work**	**student**	**Business and professional**	**unemployed**
ATPD (n =34)	17	8	3	1	5
Other psychosis (n =16)	10	5	1	0	0
Total (n =50)	27	13	4	1	5

	VALUE	**P-VALUE**	**SIGNIFICANCE**
CHI-SQUARE	3.478	0.481	Not Significant

df = 4;

On comparison of occupation between the ATPD and other psychosis group the difference was not statistically significant. More than 50% of patients in ATPD group were laborers and cultivators

COMPARISON OF OCCUPATION BETWEEN ATPD AND OTHER PSYCHOSIS GROUP

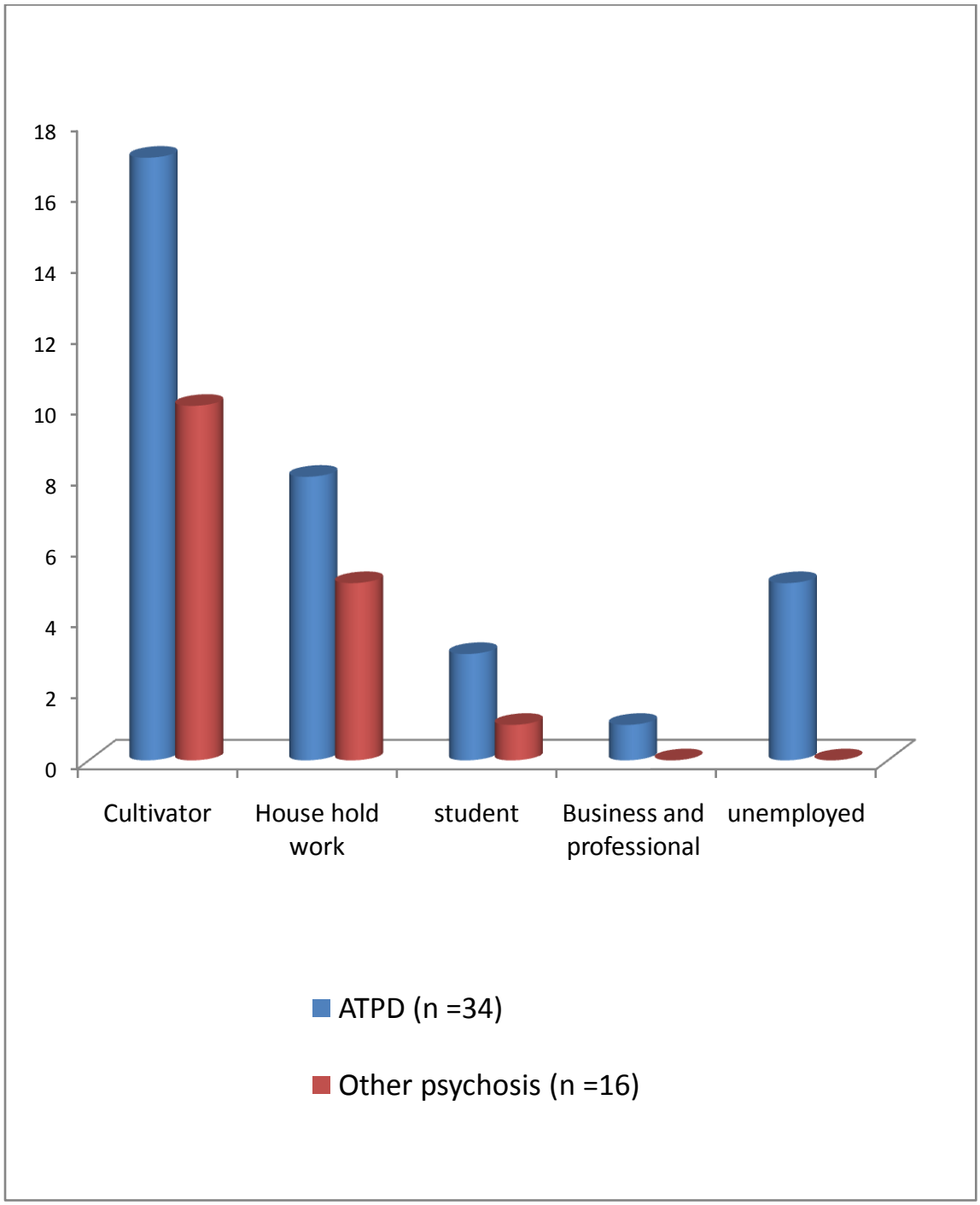

Fig. 7

PREDISPOSING CHARACTERISTICS AND DIAGNOSIS AT 3 MONTHS:

TABLE 9:

FAMILY PSYCHO PATHOLOGY AND DIAGNOSIS AT 3 MONTHS

DIAGNOSIS	FAMILY HISTORY	
	Present	**Absent**
ATPD (n =34)	15	19
Other psychosis (n =16)	9	7
Total (n =50)	24	26

	VALUE	P-VALUE	SIGNIFICANCE
CHI-SQUARE	0.642	0.423	Not Significant

df = 1

Family history of mental illness was absent in 56% of cases among ATPD groups. And the difference between 2 groups based on family history of mental illness was not statistically significant.

COMPARISON OF FAMILY PSYCHOPATHOLOGY BETWEEN ATPD AND OTHER PSYCHOSIS GROUP

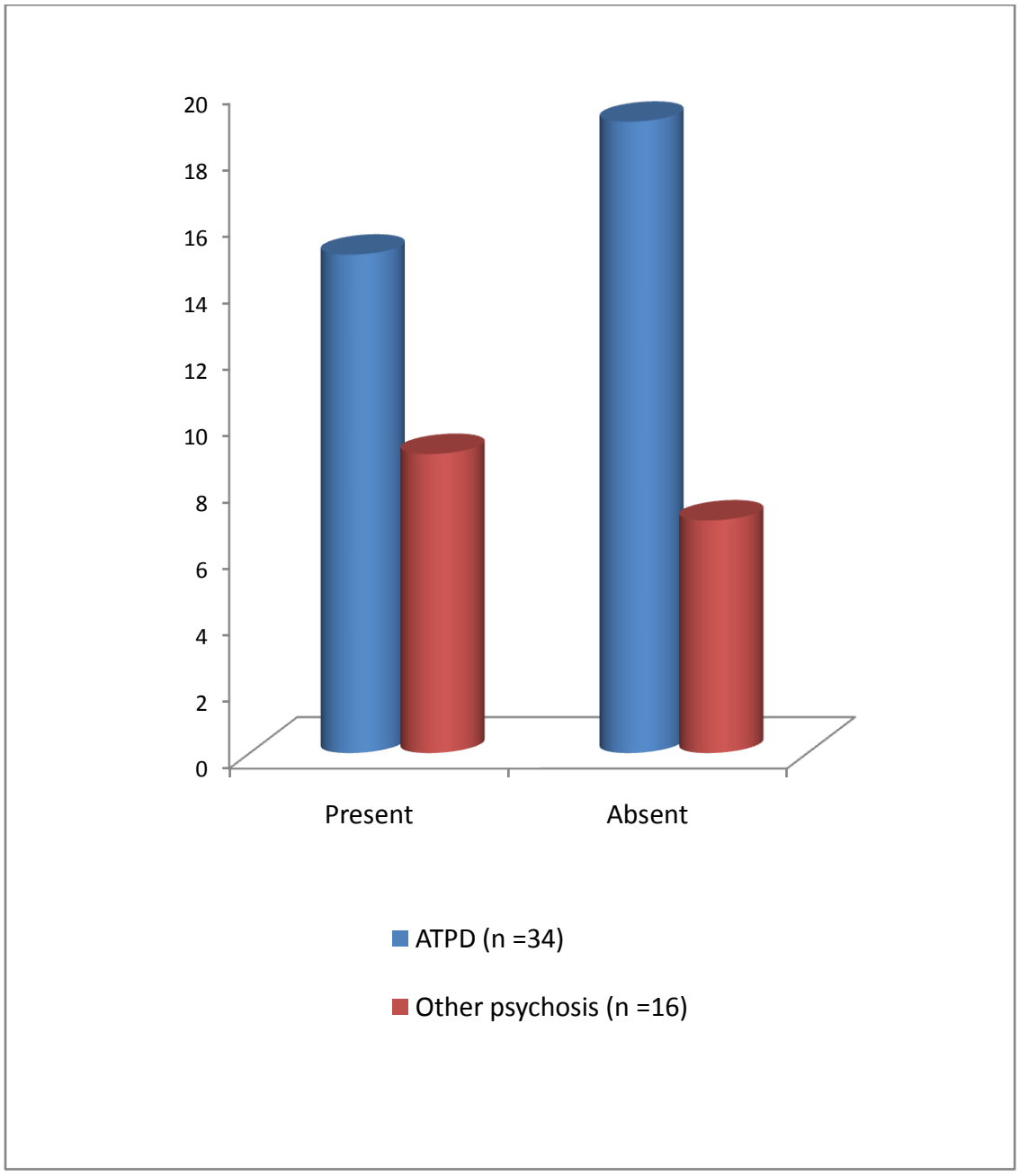

Fig. 8

PRECIPITATING FACTOR AND DIAGNOSIS AT 3 MONTHS

Table 10:

Stressor and diagnostic at 3 months.

DIAGNOSIS	STRESSOR	
	Present	**Absent**
ATPD (n =34)	11	23
Other psychosis (n =16)	7	9
Total (n =50)	18	32

	VALUE	P-VALUE	SIGNIFICANCE
CHI-SQUARE	0.613	0.434	Not Significant

df = 1

The presence of psychological stressor preceding the onset of psychosis was seen in only 32.35% of cases and was absent in 68% of cases in ATPD group. And there were no significant difference between the two groups for stressor preceding the onset of psychosis

COMPARISON OF PRECIPITATING FACTOR BETWEEN ATPD AND OTHER PSYCHOSIS GROUP

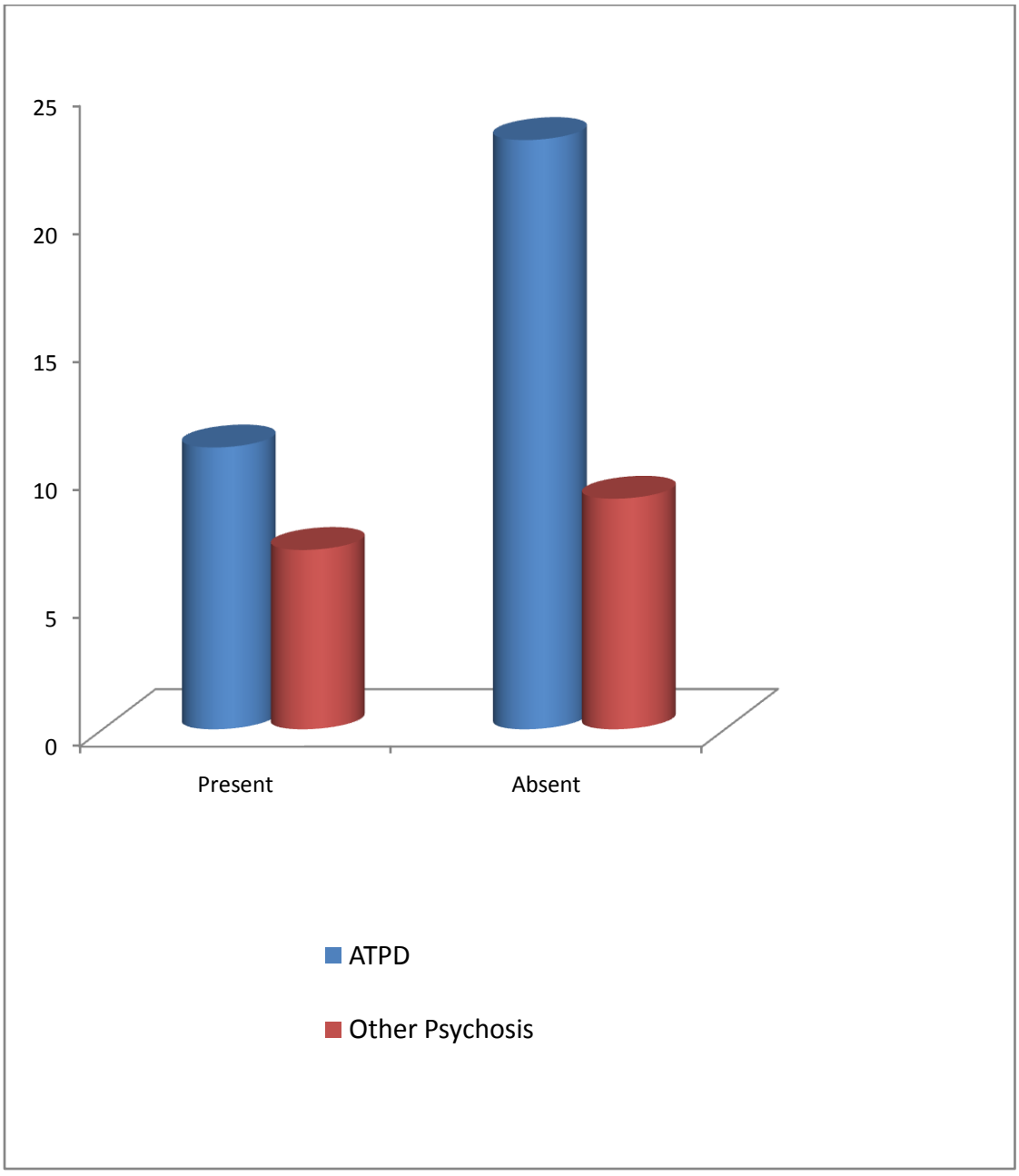

Fig.9

CLINICAL VARIABLES AND DIAGNOSIS AT 3 MONTHS:

Table 11:

Index diagnosis n = 50

ICD-10	DIAGNOSIS	N	%
F 23.0	POLYMORPHIC	16	32
F 23.1	POLYMORPHIC WITH SYMPTOMS OF SCHIZOPHRENIA	10	20
F 23.2	SCHIZOPHRENIA LIKE	5	10
F 23.3	PREDOMINANTLY DELUSIONAL	2	4
F 23.8	OTHER ATPD	5	10
F 23.9	UNSPECIFIED ATPD	12	24

The diagnostic sub grouping of ATPD cases at index into specific and non specific categories shows that 52% of cases belong to polymorphic category(both with and without symptoms of schizophrenia). 34% belong to non specific categories which included others and unspecified ATPD.

Table 12:

INDEX ICD DIAGNOSIS AND DIAGNOSIS AT THREE MONTHS

Index ICD-10 diagnosis (N=50)	ATPD	Schizophrenia	unspecified non-organic psychosis	Mood Disorder	Delusion Disorder
F 23.0, Polymorphic	12	0	3	1	0
F 23.1, Polymorphic with symptoms of Schizophrenia	5	0	3	2	0
F 23.2, Schizophrenia like	3	2	0	0	0
F 23.3, Predominantly delusional	0	0	0	0	2
F 23.8, Other ATPD	4	0	0	1	0
F 23.9, Unspecified ATPD	10	1	1	0	0

The distribution of sub categories of ATPD cases at 3 months is shown in table 12. Among the sub categories that retained the index diagnosis of ATPD, the percentage varied between 50 -83.3% for [f23.0,f23.1,f23.2,f23.8,f23.9] higher percentage of cases that retained diagnosis belonged to acute polymorphic disorder without schizophrenic symptoms and the non specific categories of other ATPD.

Almost all the cases of f23.3 other acute predominantly delusional psychotic disorders changed to a diagnosis of delusional disorder and was found to be least stable group.

TABLE 13:

RANK ORDER FREQUENCY OF SYMPTOMS OF SCAAPS

Symptoms	**ATPD(n = 34) %**	**Symptoms**	**Others (n =16) %**
lack of insight	94.117	Delayed Sleep	100
Irrelevant speech	91.176	Early awakening	100
Delayed Sleep	88.235	2nd person auditory hallucinations	93.75
Irritability	88.235	Irrelavant speech	93.75
Hostile irritability	88.235	Lack of insight	87.5
Agitation	79.4117	Irritability	81.25
2nd person auditory hallucinations	76.47	Delusion of persecution	81.25
Poor intellectual rapport	73.529	Poor intellectual rapport	75
Over activity	70.588	Loss of Appetite	68.75
Delusion of persecution	67.647	Mood congruent auditory hallucinations	68.75
Suspicion	64.705	Agitation	68.75

Loss of Appetite	64.7	Suspicion	68.75
Delusion of reference	58.82	Hostile irritability	62.5
Inappropriate or bizarre behaviour	55.88	Tension	56.25
Perplexity	52.94	Ideas of reference	56.25
Early awakening	44.117	Third person auditory hallucinations	56.25
Worrying	41.176	Worrying	50
Mood congruent auditory hallucinations	39.294	Delusion of reference	50
Tension	38.235	Depressed Mood	43.75
Depressed Mood	38.235	Social With Drawal	37.5

Rank order frequency of symptoms of ATPD and other group are shown in table: 13. The 20 most frequent symptoms among those seen in SCAAPS schedule are listed.

The most common symptoms in the ATPD group are lack of insight, Irrelevant speech, Delayed Sleep, Irritability, Hostile irritability, Agitation, 2nd person auditory hallucinations, Poor intellectual rapport, Over activity, Delusion of persecution, Suspicion, Loss of Appetite, Delusion of reference, Inappropriate or bizarre behavior, Perplexity, Early awakening, Worrying, Mood congruent auditory hallucinations, Tension, Depressed Mood

The most common symptoms in the Other group are Delayed Sleep, Early awakening, 2nd person auditory hallucinations, Irrelevant speech, Lack of insight, Irritability, Delusion of persecution, Poor intellectual rapport, Loss of Appetite, Mood congruent auditory hallucinations, Agitation, Suspicion, Hostile irritability, Tension, Ideas of reference, Third person auditory hallucinations, Worrying, Delusion of reference, Depressed Mood, Social Withdrawal.

INDEX SYMPTOMS ON SCAAPS AND DIAGNOSTICS AT 3 MONTHS.

On comparison for psychopathology between groups on symptom rated on SCAAPS, mood congruent auditory hallucinations, third person auditory hallucinations, over activity, hostile irritability, poor emotional rapport, anxiety were statistically significant as shown in table 14.

Among the six symptoms over activity and hostile irritability was present significantly more in ATPD group.

Symptoms of poor emotional Rapport and anxiety were significantly less in ATPD group.

Mood congruent auditory hallucinations, third person auditory hallucinations were significantly higher in other psychosis group compared to ATPD group.

TABLE 14:

SCAAPS Symptom	**Diagnosis**	**present**	**Absent**	**χ2**	**DF**	**P-value**
Mood congruent auditory hallucinations	ATPD	12	22			
	Others	11	5	4.903	1	0.027
Third person auditory hallucinations	ATPD	3	31			
	Others	9	7	13.417	1	0.001
overactivity	ATPD	24	10			
	Others	4	12	9.177	1	0.002
hostile irritability	ATPD	30	4			
	Others	10	6	4.504	1	0.034
poor emotional rapport	ATPD	4	30			
	Others	6	10	4.504	1	0.034
Anxiety	ATPD	2	32			
	OTHERS	6	10	8.093	1	0.004

TABLE 15:

PANSS PSYCHOPATHOLOGY AND DIAGNOSIS AT 3 MONTHS

PANSS ITEMS	DIAGNOSIS	N	MEAN	SD	P-VALUE
P3 hallucinatory behavior	ATPD	34	3.53	1.398	0.011
	Others	16	4.63	1.31	
N-Total	ATPD	34	8.44	2.135	0.002
	Others	16	12.5	6.763	
G-Total	ATPD	34	27.71	6.922	0.008
	Others	16	34	8.664	

On assessment of severity of psychopathology on PANNS 3 variables emerged significant between the two groups, namely P3 hallucinatory behavior, N-Total and G-total.

The mean values of all the 3 variables in the ATPD groups was lesser compared to other psychosis group.

TABLE 16:

GAF SCORES AT 3 MONTHS

Diagnosis	N	GAF Mean	Std. Deviation
ATPD	34	73.26	5.224
Other Psychosis	16	52.63	9.186

	VALUE	P-VALUE	SIGNIFICANCE
T –TEST	10.134	0. 000	Significant

DF = 48

On comparison of global assessment of functioning at 3 months, there was significant difference between the two groups(p=0.000s). The mean GAF score of ATPD group was significantly higher (73.26) when compared with the other group.

DISCUSSION

The category of ATPD was introduced in 10th edition of ICD10. Since its introduction the authors had pointed out that the knowledge regarding ATPD is very limited and there are only few studies which have been published. The low frequency of the disorders makes it difficult to recruit large number of patients. This limitation also applies to the present study.

However the strengths of the study were that prospective study design was employed and cases were recruited using ICD (DCR) criteria for F23 (ATPD). To increase objectivity and decrease bias the follow up assessments were done by principle investigator at baseline 1 week, 1 month, 2 month and 3 month after initial contact. And the index assessments were corroborated with assessment made independently by assistant professors and professors.

Standardized scales were used for the assessment of presence of stressor (Gourmet Singh's Life event scale) and for symptomatology Schedule for clinical assessment of Acute Psychotic state were used, which was widely used in prior studies, PANSS was administered to assess the psychopathology in various domains.

The primary aim of the study was to assess the diagnostic stability. In this study 68% (n=34) of 50 cases retained the index diagnosis of ATPD at 3 months. (Table 1).

Among 32% cases (n=16) requiring diagnostic revision, 14% cases were diagnosed as unspecified non organic psychosis, 8% as mood disorder, 6% schizophrenia and 4% as Delusional Disorder.

Few studies were comparable to these results. Thangadurai et al reported a diagnostic stability of 64% and 9% converted to affective disorders.

Similar rates of higher Diagnostic stability (63% and 60%) were reported by Abe et al and Sudha et al. However in the study by Abe et al, there was a 30% change in diagnosis to schizophrenia.

Revision of diagnosis to schizophrenia and mood disorders was reported by Jorgensen et al 1985. Castagnini et al reported that the principle diagnostic changes were to F2 schizophrenia and related disorder 29.3 % and F3 affective disorder 11.0%. The overall stability rate in this study was about 39%

SOCIODEMOGRAPHIC CHARACTERISTICS:

In table 2 the mean age of ATPD cases was 27.18 years. Most of cases belong to younger age group. This finding has been reported by ICMR study on acute psychosis, Menon et al, Sajith et al and Das et al.

In table 3 the ATPD group was found to have female preponderance which is similar to the earlier studies by Susser E varma et al and Malhothra S, Wig NN et al, 1998.

In this study the ATPD were diagnosed more among unmarried population which was in contrast to study of ICMR which reported more prevalence among married individuals.

In this study higher percentage of ATPD patients belonged to Low socio economic stats and had only primary level of education.

This was similar to earlier study by Jorgensen(1985), Malhothra et al 1987, ICMR 1989, Sajith et al (2002) and Das et al (2001)

PREDISPOSING AND PRECIPITATING FACTORS:

Table 9 shows that significant family psychopathology was absent in ATPD group. Absence of family history is supportive of ATPD being recognized as a genetically and nosologically distinct group.

PRECIPITATING FACTORS:

The presence of stressor (table 10) preceding the onset of psychosis was seen in 32% of cases . This finding is similar to the one reported by Varma et al which confirmed the presence of significance stressor in 34% of cases before

the onset of illness ,But compared to other studies the occurrence of stressor was significantly lesser than the previous studies.

CLINICAL VARIABLES:

Index ICD 10 (Table 11) diagnosis was predominantly of polymorphic type followed by non specific categories of F23.8 and F23.9 . In three month follow up 12 out of 16 cases of F23 diagnosis retained the diagnosis of ATPD. This finding was similar to the diagnostic stability reported by Sajith et al. in a cohort of APPD patients.

The most common symptoms in ATPD group were listed in Table13

This is almost similar to symptom profile reported by ICMR study and studies by Okasha et al.

Table 14 shows the symptoms of over activity and hostile irritability was significantly higher in ATPD group and anxiety was significantly lesser in ATPD group. The finding of lesser Anxiety in ATPD group was a contrasting finding to the one reported by Pillman, Marneros (2001. 2003).

The finding of lesser frequency of occurrence of auditory hallucinations was similar to the finding of HASBAP study. This study reported auditory hallucinations are less frequent in ATPD than in positive schizophrenia but were not uncommon

On PANSS (Table 15) assessment patients with ATPD scored significantly lesser in N-Total and G-Total which confirms the finding reported by Mojtbai et al 2003, that NARP patient scored significantly lesser in negative symptoms scores. Patients with ATPD group had lesser positive psychopathology compared to schizophrenia group.

Higher GAF scores reflecting higher level of functioning at follow up compared to other group (Table 16) was similar to prior studies (Jorgansen 1995 and HASBAP study)

The above Discussed findings indicated that diagnosis of ATPD to be valid category with a diagnostic stability of more that 50% and reported more commonly in female, with younger age of onset less than 30 yrs and absent family history and clinical variables of lesser negative psychopathology and better functioning.

However in this study we found out distinct clinical characteristics of ATPD, predictive power of these clinical variables to the diagnosis of ATPD could not be confirmred due to its smaller sample size and future studies with large sample size are required to find any relationship between sociodemographic variables ,clinical variables and diagnosis of ATPD.

SUMMARY AND CONCLUSION

This study was undertaken to assess the diagnostic stability and to study the clinical characteristics of Acute and transient psychotic Disorder.

Standardized criteria were used for assessment and a prospective study design was employed. 50 cases completed the study and they were divided into 2 groups on basis of diagnosis at 3 months and compared for difference in sociodemographic variable and clinical variables.

The patients were assessed using SCAAPS schedule for(sociodemographics, psychiatric history and symptomatology), PANSS, presumptive life events scale and GAF at 48hrs, 1 week, 1 month, 2 month, 3 month.

The data were analyzed using SPSS version 14.

68% retained diagnosis of ATPD indicating higher stability of diagnosis. On comparisons between the two groups the results were not statistically significant for the sociodemographic variable, Family psychopathology and stressor.

The results also indicate that a female preponderance, younger age of onset and pt belonging to LSES were present more common in the ATPD group.

Presence of over activity and hostile irritability was significantly higher in ATPD group and anxiety, poor emotional rapport, mood congruent and third person auditory hallucinations was significantly lesser in ATPD groups.

ATPD group had significantly higher functioning compared to other Diagnostic groups.

This study demonstrated the ATPD to be valid category and diagnostically stable group. But future long term studies are needed in identifying clinical variables predictive of outcome and studies regarding ATPD subcategories of ICD 10 and their outcome are required.

METHODOLOGICAL LIMITATIONS

The most significant limitation of the study is the small sample size and limited follow up period this partly reflects the rarity of ATPD cases

The true natural history of psychotic disorder cannot be determined from studies of treated population. In a tertiary care setting such as the one in the study was conducted it is unlikely that the patients with psychosis would be anti-psychotic free.

Cultural differences in the clinical presentation of ATPDs suggest caution in generalizing the findings to other cultural settings. The findings of this study need replication in the light of new concept of ATPD and their subtypes in ICD 10.

Long term studies are needed to assess the diagnostic stability of sub categories of ATPD.

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APPENDICES

APPENDIX CONTENTS

APPENDIX I

1) F-23, ICD-10 Diagnostic Criteria for Acute and Transient Psychotic Disorders. World Health Organization: The ICD-10 Classification of Mental and Behavioral Disorders: Diagnostic Criteria for Research. (C) World Health Organization, Geneva, 1993.

G1. There is acute onset of delusions, hallucinations, incomprehensible or incoherent speech, or any combination of these. The time interval between the first appearance of any psychotic symptoms and the presentation of the fully developed disorder should not exceed 2 weeks.

G2. If transient states of perplexity, misidentification, or impairment of attention and concentration are present, they do not fulfill the criteria for organically caused clouding of consciousness as specified for delirium, not induced by alcohol and other psychoactive substances, criterion A.

G3. The disorder does not meet the symptomatic criteria for manic episode depressive episode, or recurrent depressive disorder.

G4. There is insufficient evidence of recent psychoactive substance use to fulfill the criteria for intoxication, harmful use, dependence, or withdrawal states. The continued moderate and largely unchanged use of alcohol or drugs in amounts with the frequency to which the individual is accustomed does not necessarily rule out the use of acute and transient psychotic disorders; this must be decided by clinical judgment and the requirements of the research project in question.

G5. Most commonly used exclusion clause. There must be no organic mental disorder or serious metabolic disturbances affecting the central nervous system (this does not include childbirth).

A fifth character should be used to specify whether the acute onset of the disorder is associated with acute stress (occurring 2 weeks or less before evidence of first psychotic symptoms):

- Without associated acute stress
- With associated acute stress

For research purposes, it is recommended that change of the disorder from a nonpsychotic to a clearly psychotic state is further specified as either abrupt (onset within 48 hours) or acute (onset in more than 48 hours but less than 2 weeks).

I. Acute polymorphic psychotic disorder without symptoms of schizophrenia

A. The general criteria for acute and transient psychotic disorders must be met.

B. Symptoms change rapidly in both type and intensity from day to day or within the same day.

C. Any type of either hallucinations or delusions occurs, for at least several hours at any time from the onset of the disorder.

D. Symptoms from at least two of the following categories occur at the same time.

1. Emotional turmoil characterized by intense feelings of happiness or ecstasy or overwhelming anxiety or marked irritability.

2. Perplexity, or misidentification of people or places;

3. Increased or decreased motility, to a marked degree.

E. If any of the symptoms listed for schizophrenia, criterion G (1) and (2) are present, they are present only for a minority of the time from the onset; i.e., criterion B of acute polymorphic psychotic disorder with symptoms of schizophrenia is not fulfilled.

F. The total duration of the disorder does not exceed 3 months.

II. Acute polymorphic psychotic disorder with symptoms of schizophrenia.

A. Criteria A, B, C, and D of acute polymorphic psychotic disorder must be met

B. Some of the symptoms for schizophrenia must have been present for the majority of the time since the onset of the disorder, although the full criteria need not be met, i.e., at least one of the symptoms in criteria G1 (1) a to G1 (2) c.

C. The symptoms of schizophrenia in criterion B above do not persist for more than 1 month.

III. Acute schizophrenia-like psychotic disorder

A. The general criteria for acute and transient psychotic disorders must be met

B. The criteria for schizophrenia are met, with the exception of the criterion of duration.

C. The disorder does not meet criteria B, C, and D for acute polymorphic psychotic disorder.

D. The total duration of the disorder does not exceed 1 month

IV. Other acute predominantly delusional psychotic disorders

A. The general criteria for acute and transient psychotic disorders muse be met

B. Relatively stable delusions and/or hallucinations are present but do not fulfill the symptomatic criteria for schizophrenia.

C. The disorder does not meet the criteria for acute polymorphic psychotic disorder.

D. The total duration of the disorder does not exceed 3 months.

V. Other acute and transient psychotic disorders

Any other acute psychotic disorders that are not classifiable under any other category in acute and transient psychotic disorders (such as acute psychotic states in which definite delusions or hallucinations occur but persist for only small proportions of the time) should be coded here. States of undifferentiated excitement should also be coded here if more detailed information about the patient's mental state is not available, provided that there is no evidence of an organic cause

APPENDIX II

INDIAN COUNCIL OF MEDICAL RESEARCH

Collaborative Study on Phenomenology and Natural History of Acute Psychosis

(Schedule for Clinical Assessment of Acute Psychotic States)

Name of Patient.....

Address (complete address to be noted down)

(a) Local address .....
.....

(b) Permanent address .....
.....
.....

Identification number of the patient in the facility.....

(1-3)	Job Number	1 3 4
(4-5)	Card design	1 1
(6)	Name of centre (Key : Patiala 1, Goa 2 Bikaner, V, Vellore 4)	☐
(7-8)	Card number	0 1
(9-11)	Patient's ICMR serial number	☐ ☐ ☐
(12-13)	Psychiatrist who rated the schedule Name.....	☐ ☐ ☐
(14)	Was this schedule filled as a part or reliability interview ? (Key : Yes 1, 2)	☐
(15-16)	Psychiatrist who interviewed the patient Name.....	☐ ☐
(17-18)	Age of patient (years)	☐ ☐
(19)	Sex of patient (Key : Male 1, Female 2)	☐
(20)	Blank	☐
		Date Month Year
(21-26)	Date when it was filled	/ /

(27) Marital status ☐
(Key : Single/Never married 1, married 2, separated 3, divorced 4, widowed 5, other 6, unknown 9)

(28) Educational status ☐
(Key : Illiterate 1, literate but not attended any school 2, completed primary 3, completed middle 4, completed secondary 5, technical after secondary 6, college 7, and other, 8, unknown 9)

(29-30) Blank ☐ ☐

sources of information used to fill in this schedule
(Key : Yes 1, No 2)

(31) Interview with patient ☐
(32) Interview with key informant ☐
(33) Interview with more than one informant ☐
(34) Other sources ☐

PART A—SCREENING PROFORMA : GIVEN SEPARATELY

PART B—PSYCHIATRIC HISTORY AND SOCIAL DESCRIPTION

On the basis of your assessment of this patient; please answer the following question:

B.1 (53) How many days prior to the patient's initial assessment was the onset of psychiatric symptoms described in part A? ☐

B.2 (54) It this the first episode of any mental illness (including neurotic disorder) this patient has ever had? ☐

(Key: Yes 1, No 2, Uncertain 9)

B.2.1 If no, specify when earlier episode occurred, describe briefly their nature and how they were treated.

B.3. (55) How rapid was the onset of psychotic symptoms ? □

(Key : Acute onset, one or more psychotic symptoms appeared within days (upto a week); no psychotic symptoms in the preceding three months 1

Acute onset of one or more psychotic symptoms (within days, upto a week) but existence of other non-psychotic symptoms in the preceding 3 months likely or certain 2

Sub-acute onset, psychotic symptoms developed over a period of upto one month; existence of psychiatric symptoms in the preceding three months can be safely excluded 3

Sub-acute onset, psychotic symptoms developed over a period of upto one month; previous existence of other, non-psychotic symptoms in the preceding three months likely or certain 4

Available information inadequate for making any judgement about mode of onset 9

B.4 (56) Was the onset of this episode of mental illness preceded, within three months by any event which of the patient experienced as stressful, threatening or humiliating ?
(Key : Yes 1, No 2, Uncertain 9)

B.4, 1 (57-58) If yes, how many weeks ago ? □
(If uncertain 9)

B.4.2 If yes, specify nature and event

B.5 (59) Was the onset of episode of mental disorder preceded, within three months by any physiological, or somatic stress like infectious disease, fever of any sort, injury, exhaustion, other physical disease, child birth etc.?
(Key : Yes 1, No 2, Uncertain 9) □

B.5.1 (60-61) If yes, specify how many weeks ago. ☐☐
(Key : Yes 1, No 2, Uncertain 9)

B.5.2 If yes, specify nature of physiologic or somatic strain

B.6 (62) Has the patient been experiencing any chronic difficulties (tensions in interpersonal relationship, or other problems of living) throughout the last year) ☐
(Key : Yes 1, No 2, uncertain 9)

B.6.1 If yes, specify nature of problem

	Drugs	Alcohol
B.7 (63-64) Is there any evidence of drug (e.g. prescription drugs, LSD, hashish, amphetamines, sedatives, others) or alchol abuse by this patient during the last year ?	☐	☐

Key :

Yes,	1
No.	2
Suspicion only	3
Not known	9

B.7.1 If yes, specify nature of abuse

B.8 (65) Is there any evidence of abnormal premorbid personality traits in this patient. ☐

(Key : Yes 1, No 2, Uncertain 9)

B.8.1 If yes, describe such traits

B.9 (66) Is there any evidence of abnormal premorbid social functioning in patients history i.e.(i) nonparticipation in appropriate roles and activities expected of a 'normal' person in the patients socio-cultural context and or (ii) participation in deviant 'social activities or roles as generally defined by other members in this society. ☐

(Key : yes 1, No 2, Uncertain 9)

B.9.1 If yes, describe abnormal functioning

B.10 (67) Is there any evidence of mental disorder in any of the first degree relatives of this patient (father, mother, siblings, children (including sibling) regardless of whether living or dead ? ☐

(Key : Yes 1, No 2, Uncertain 9)

B.10.1 If yes specify which relatives and nature of disorder if known

B.11 (68) Is this patient living with a person suffering from mental disorder (whether related or not) ? ☐

(Key : Yes 1, No 2, Uncertain)

B.11.1 If yes give details.

B.12 (69) Rate the patient's socio economic standing with regard to the catchment area population : ☐

Key : 1. Highest level
2. Above average
3. Average
4. Below average (economically disadvantaged but not destitute)
5. the poorest group (i.e. poverty stricken, destitute)
6. Uncertain/unknown

B.13 (70) Is the patient a member of any culturally identifiable minority group (e.g. caste, ethnic, racial group etc.) ? (Key : Yes 1, No 2, Uncertain 9) ☐

B.13.1 If yes, specify group

B.14 (71) Is there any evidence of other socio-economic, cultural or demographic factors that distinguish the patient from an "average" member of his/her society or socio-cultural environment ? □

B.14.1 If yes, please describe such factors

B.15 (72) Religion

Key : Hindu 1 Christian 4
Sikh 2 Buddhist 5
Muslim 3 Others 6

B.16 (73) Caste—Name □
(Key : S.C./S.T. 1, Other 2)

B.17 (74) Occupation □

(Key : 1 Cultivator
2 Labourer
3 Household work
4 Student
5 Business and professional
6 None
7 Others)

B.18 (75-76) State of origin □□

INDIAN COUNCIL OF MEDICAL RESEARCH

COLLOBORATIVE STUDY ON PHENOMENOLOGY & NATURAL HISTORY OF ACUTE PSYCHOSIS

Screening Criteria for Acute Psychotic States

(Use Codes : Yes—1, No—2, uncertain—9)

Patient's name :

Age :

A. 1	(35)	Patient's age between 15 and 50 years old	☐
A. 2	(36)	Onset of symptoms within 1 month of initial assessment If both rated '1' go on to A.3	☐
A. 3		Check if the following features can be safely excluded in this case.	☐
A. 3.1	(37)	Gross organic brain disorder.	☐
A. 3.2	(38)	Epilipsy	☐
A. 3.3	(39)	Mental retardation	☐
A. 3.4	(40)	History of previous episode of psychotic illness.	
A. 3.5	(31)	Has been on continuous antipsychotic treatment for more than last one week	☐
A. 3.6	(42)	Residence beyond the defined catchment area If all rated '2' go on to A. 4	☐
A. 4	(43)	A sudden onset of psychotic symptoms developing with days, upto 2 weeks If rated '1' go on to A.5	
A. 5		Check if any of the following features are present in this case.	
A. 5.1	(44)	Hallucinations	☐
A. 5.2	(45)	Delusions (any content)	
A. 5.3	(46)	Confusion or disorientation	☐
A. 5.4	(47)	Grossly inappropriate or socially undesirable behaviour	☐

A. 5.5 (48) Marked excitement ☐

A. 5.6 (49) Marked withdrawal ☐

A. 5.7 (50) Marked Elation

A. 5.8 (51) Marked depression ☐

if any two or more rated '1'

Consider this patient eligible for inclusion. However, the presence of either hallucinations or delusions, even when present alone, would qualify the patient for inclusion.

Certain cases fulfilling only one of the above criteria may still be included if there is sufficient reason to believe that he/she is suffering from an 'acute' psychotic disorder. Such reasons should be specified below :

This patient is provisionally included.

Name of the interviewer

Date of assessment.

Case reviewed : Any auditional information

Name of interviewer.

Date

Case reviewed : Any additional information.

.....

.....

.....

This patient is included/excluded

Name of interviewer :

Date of assessment :

PART C—SYMPTOM CHECK LIST

INSTRUCTIONS

The following check list should be filled in on the basis of a mental state assessment, including an examination of the patient a review of the case records and if possible an interview with a key informant.

Most items corresponds to PSE items whose number, according to the 9th edition, are given in brackets, and they are defined by the PSE glossary of definition 9th edition.

The rating should be : 1 definitely present during the specified period of time.
2 not present
9 unknown or uncertain

No symptom should be rated as present unless there is clear evidence to support such rating. The rater should utilise all available information to make a best estimate about the appropriate ratings. For every symptom rated as present a description should be provided on the opposite page.

Col. No	Symptoms	Anytime in the 2 weeks prior to initial assessment	Initial assessment (within 48 hours)	SCAAPS 1 wks	2 wks	3 wks	4 wks	5 wks	6 wks	3 mth	6 mths	1 year
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
(30-40)	C.1 Worrying (3)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(41-51	C.2 Tension & anxiety (7,8,10,11-17)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	C.3 Appetite, sleep & libido											
(52-62)	3.1 Loss of appetite (weight) (34)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(63-73)	3.2 Delayed sleep (35)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

(1-8) | 1 | 3 | 4 | 2 | 1 | 0 | | 2 |

Col. No	Symptoms	Anytime in the 2 weeks prior to initial assessment	Initial assessment (within 48 hours)	SCAAPS 1 wks	2 wks	3 wks	4 wks	5 wks	6 wks	3 mth	6 mths	1 year
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
(21-31)	3.3 Early wakening (37)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(32-42)	3.4 Loss of libido (38)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	C.4 Mood disturbances											
(43-53)	4.1 Depressed mood (23)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	4.2 Hopelessness (24)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(65-75)	4.3 Suicidal plans or acts (25)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	1 3 4 2 1 0 3											
(21-31)	4.4 Self-depreciating thoughts (non-delusional) (29)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(32-42)	4.5 Subjective anergia and retardation (26)			☐	☐	☐	☐	☐	☐	☐	☐	☐
(43-53)	4.6 Diurnal variation (27)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	4.7 Expansive mood (41)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(65-75)	4.8 Subjective ideomotor pressure (42)			☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	1 3 4 2 1 0 4											

(21-31)	4.9 Grandiose ideas and actions (non-delusional) (43)											
(32-42)	C.5 Irritability (40)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(43-53)	C.6 Social withdrawal (28) C.7 Neurotic symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	7.1 Phobias (17)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(65-75	7.2 Obessions or compulsions (44-46)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	1 3 4 2 1 0 5											
(21-31)	7.3 Conversion and other hysterical symptoms (101)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(32-42)	7.5 Ideas of reference (non-delusional) (31)		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(43-53)	C.8 Negative Symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	8.1 Loss of interest (22)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(65-75)	8.2 Lack of initiative	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	1 3 4 2 1 0 6											
(21-31)	8.3 Decreased ability to enjoy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(32-42)	8.4 Difficulties in concentration (20)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(43-53)	8.5 Memory difficulties	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	8.6 Loss of energy (36) C.9 Non-hallucinatory Perceptual dioerssrd	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Col. No.	Symptoms	Anytime in the last 2 weeks initial assessment	Initial assessment 48 hours)	SCAAPS (in weeks) 1 wks	2 wks	3 wks	4 wks	5 wks	6 wks	3 mth	6 mths	1 year
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
(65-75)	9.1 De-realization (47)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	1 3 4 2 1 0 7											
(21-31)	9.2 Depresonalization (48)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(32-42)	9.3 Changed perception	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	C.10 Subjectively experienced thought disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(43-53)	10.1 Thought insertion (55)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	10.2 Thought broadcast (56)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(65-75)	10.3 Thought echo or commentary (57)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	1 3 4 2 1 0 8											
(21-31)	10.4 Thought block (58)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(32-42)	10.5 Delusion of thoughts being read (59)			☐	☐	☐	☐	☐	☐	☐	☐	☐
	C.11 Hallucinatory preceptual disorders (hallucinations and pseudohallucinations)											

(43-53) 11.1 Auditory, non-verbal (60) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(54-64) 11.2 Verbal hallucination based on affect, or voices calling subject (61) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(65-75) 11.3 Voices speaking to subject (63) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(1-8)	1	3	4	2	1		0	9

(21-31) 11.4 Voices speaking about subject (62) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(32-42) 11.5 Dissociative hallucinations (66-67) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(43-53) 11.6 Visual hallucinations (68, 69, 70) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

C.12 Delusions

(54-64) 12.1 Delusions of control (17) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(65-75) 12.2 Delusions of reference (72-73)

(1-8)	1	3	4	2	1		1	0

(21-31) 12.3 Delusions of persecution (74) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(32-42) 12.4 Grandiose delusions (75, 76, 77) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(43-53) 12.5 Religious delusions (78) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(54-64) 12.6 Sexual delusions (86) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(65-75) 12.7 Hypochondriacal deluions (91) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Col. No.	Symptoms	Anytime in the last 2 weeks prior to initial assessment	Initial assessment (within 48 hours)	SCAAPS (in wkkeees) 1 wks	2 wks	3 wks	4 wks	5 wks	6 wks	3 mth	6 mths	1 year
(1-8)	| 1 | 3 | 4 | 2 | 1 | | 1 | 1 |											
(21-31)	12.8 Delusions of quit (88)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(32-42)	12.9 Other delusions (79-82)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	C.13 Observed disorders of sensorium											
(43-53)	13.1 Disorientation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	13.2 Clouding of consciousness (102)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(65-75)	13.3 Dissociative state (100)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	| 1 | 3 | 4 | 2 | 1 | | 1 | 2 |											
(21-31)	13.4 Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	C.14 Observed disorders in behaviour											
(32-42)	14.1 Agitation or excitement (111,112)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(43-53)	14.2 Over-activity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	14.3 Retardation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(65-75)	14.4 Stupor	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	| 1 | 3 | 4 | 2 | 1 | | 1 | 3 |											

(21-31) 14.5 Hysteriform-histrionic behaviour (101) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(32-42) 14.6 inappropriate or bizarre behaviour (113, 116 , 119) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

C.15 Observed affect

(43-53) 15.1 Anxiety (120) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(54-64) 15.2 Depression (121) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(65-75) 15.3 Elation (123) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(1-8) | 1 | 3 | 4 | 2 | 1 | | 1 | 4 |

(12-31) 15.4 Hostile irritability (124) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(32-42) 15.5 Suspicion (125) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(43-53) 15.6 Perplexity (12.6) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(54-64) 15.7 Lability of mood (127) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(65-75) 15.8 Blunted affect (128) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(1-8) | 1 | 3 | 4 | 2 | 1 | | 1 | 5 |

(21-31) 15.9 Apathy (54) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

C.16 Observed speech

(32-42) 16.1 Slow speech (130) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(43-53) 16.2 Muteness (133) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(54-64) 16.3 Pressure of speech (131) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(65-75) 16.4 Flight of ideas (137) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(1-8) | 1 | 3 | 4 | 2 | 1 | | 1 | 6 |

(21-31) 16.5 Irrelevant, vague, idiosyncratic, tangential speech (135, 136, 138) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Col. No.	Symptoms	Anytime in the last 2 weeks prior to initial assessment	Initial assessment (within 48 hours)	SCAAPS (in weeks) 1 wks	2 wks	3 wks	4 wks	5 wks	6 wks	3 mth	6 mths	1 year
(32-42)	C.17 Other observed disorders C.18 Overall impression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(43-53)	18.1 Lack of insight (104)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(54-64)	18.2 Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(65-75)	18.3 Poor emotional rapport	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(1-8)	| 1 | 3 4 | 2 | 1 | | 1 | 7 |											
(21-31)	18.4 Poor Intellectual rapport	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(32-42)	C.19 Symptoms reflecting stressful events or situation If any symptoms are rated under C. 19 as present list below the identification number of the symptom (e.g. delusions of persecution — C. 6.3) and write a brief narrative note about the manner in which each symptom is linked to a stressful event (e.g. through denial, delusional context, psychomotor activity, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

APPENDIX 3

POSITIVE AND NEGATIVE SYNDROME SCALE

0=Absent 1=Minimal 2=Mild 3=Moderate 4=Moderate severe 5=Severe 6=Extreme

POSITIVE SCALE (P)

P1 Delusions [_]
Beliefs which are unfounded, unrealistic, and idiosyncratic. Basis for rating: Thought content expressed in the interview and its influence on social relations and behavior.

P2 Conceptual disorganization [_]
Disorganized process of thinking characterized by disruption of goal-directed sequencing, e.g., circumstantiality, tangentiality, loose associations, non sequiturs, gross illogicality, or thought block. Basis for rating: Cognitive-verbal processes observed during the course of interview.

P3 Hallucinatory behavior [_]
Verbal report or behavior indicating perceptions which are not generated by external stimuli. These may occur in the auditory, visual, olfactory, or somatic realms. Basis for rating: Verbal report and physical manifestations during the course of interview as well as reports of behavior by primary care workers or family.

P4 Excitement [_]
Hyperactivity as reflected in accelerated motor behavior, heightened responsivity to stimuli, hypervigilance, or excessive mood lability. Basis for rating: Behavioral manifestations during the course of interview as well as reports of behavior by primary care workers or family.

P5 Grandiosity [_]
Exaggerated self-opinion and unrealistic convictions of superiority, including delusions of extraordinary abilities, wealth, knowledge, fame, power, and moral righteousness. Basis for rating: Thought content expressed in the interview and its influence on behavior.

P6 Suspiciousness/persecution [_]
Unrealistic and exaggerated ideas of persecution, as reflected in guardedness, a distrustful attitude, suspicious hypervigilance, or frank delusions that others mean one harm. Basis for rating: Thought content expressed in the interview and its influence on behavior.

P7 Hostility [_]
Verbal and nonverbal expressions of anger and resentment, including sarcasm, passive-aggressive behavior, verbal abuse, and assaultiveness. Basis for rating: Interpersonal behavior observed during the interview and reports by primary care workers or family.

NEGATIVE SCALE (N)

N1 Blunted affect [_]
Diminished emotional responsiveness as characterized by a reduction in facial expression, modulation of feelings, and communicative gestures. Basis for rating: Observation of physical manifestations of affective tone and emotional responsiveness during the course of interview.

N2 Emotional withdrawal [_]
Lack of interest in, involvement with, and affective commitment to life's events. Basis for rating: Reports of functioning from primary care workers or family and observation of interpersonal behavior during the course of interview.

N3 Poor rapport [_]
Lack of interpersonal empathy, openness in conversation, and sense of closeness, interest, or involvement with the interviewer. This is evidenced by interpersonal distancing and reduced verbal and nonverbal communication. Basis for rating: Interpersonal behavior during the course of interview.

0=Absent 1=Minimal 2=Mild 3=Moderate 4=Moderate severe 5=Severe 6=Extreme

N4 Passive/apathetic social withdrawal [_]
Diminished interest and initiative in social interactions due to passivity, apathy, anergy, or avolition. This leads to reduced interpersonal involvements and neglect of daily activities.

N5 Difficulty in abstract thinking [_]
Impairment in the use of the abstract-symbolic mode of thinking, as evidenced by difficulty in classification, forming generalizations, and proceeding beyond concrete or egocentric thinking in problem-solving tasks. Basis for rating: Responses to questions on similarities and proverb interpretation, and use of concrete vs. abstract mode during the course of interview.

N6 Lack of spontaneity and flow of conversation [_]
Reduction in the normal flow of communication associated with apathy, avolition, defensiveness, or cognitive deficit. This is manifested by diminished fluidity and productivity of the verbal-interactional process. Basis for rating: Cognitive-verbal processes observed during the course of interview.

N7 Stereotyped thinking [_]
Decreased fluidity, spontaneity, and flexibility of thinking, as evidenced in rigid, repetitious, or barren thought content. Basis for rating: Cognitive-verbal processes during the course of interview.

GENERAL PSYCHOPATHOLOGY SCALE (G)

G1 Somatic concern [_]
Physical complaints or beliefs about bodily illness or malfunctions. This may range from a vague sense of ill being to clear-cut delusions of catastrophic physical disease. Basic for rating: Thought content expressed in the interview.

G2 Anxiety [_]
Subjective experience of nervousness, worry, apprehension, or restlessness, ranging from excessive concern about the present or future to feelings of panic. Basis for rating: Verbal report during the course of interview and corresponding physical manifestations.

G3 Guilt feelings [_]
Sense of remorse or self-blame for real or imagined misdeeds in the past. Basis for rating: Verbal report of guilt feelings during the course of interview and the influence on attitudes and thoughts.

G4 Tension [_]
Overt physical manifestations of fear, anxiety, and agitation, such as stiffness, tremor, profuse sweating, and restlessness. Basis for rating: Verbal report attesting to anxiety and, thereupon, the severity of physical manifestations of tension observed during the interview.

G5 Mannerisms and posturing [_]
Unnatural movements or posture as characterized by an awkward, stilted, disorganized, or bizarre appearance. Basis for rating: Observation of physical manifestations during the course of interview as well as reports from primary care workers or family.

G6 Depression [_]
Feelings of sadness, discouragement, helplessness, and pessimism. Basis for rating: Verbal report of depressed mood during the course of interview and its observed influence on attitude and behavior.

G7 Motor retardation [_]
Reduction in motor activity as reflected in slowing or lessening of movements and speech, diminished responsiveness to stimuli, and reduced body tone. Basis for rating: manifestations during the course of interview as well as reports by primary care workers or family.

G8 Uncooperativeness [_]
Active refusal to comply with the will of significant others, including the interviewer, hospital staff, or family, which may be associated with distrust, defensiveness, stubbornness, negativism, rejection of authority, hostility, or belligerence. Basis for rating: Interpersonal behavior observed during the course of interview as well as reports by primary care workers or family.

G9 Unusual thought content [_]
Thinking characterized by strange, fantastic, or bizarre ideas, ranging from those which are remote or atypical to those which are distorted, illogical, and patently absurd. Basis for rating: Thought content expressed during the course of interview.

G10 Disorientation [_]
Lack of awareness of one's relationship to the milieu, including persons, place, and time, which may be due to confusion or withdrawal. Basis for rating: Responses to interview questions on orientation.

G11 Poor attention [_]
Failure in focused alertness manifested by poor concentration, distractibility from internal and external stimuli, and difficulty in harnessing, sustaining, or shifting focus to new stimuli. Basis for rating: Manifestations during the course of interview.

G12 Lack of judgment and insight [_]
Impaired awareness or understanding of one's own psychiatric condition and life situation. This is evidenced by failure to recognize past or present psychiatric illness or symptoms, denial of need for psychiatric hospitalization or treatment, decisions characterized by poor anticipation of consequences, and unrealistic short-term and long-range planning. Basis for rating: Thought content expressed during the interview.

G13 Disturbance of volition [_]
Disturbance in the willful initiation, sustenance, and control of one's thoughts, behavior, movements, and speech. Basis for rating: thought content and behavior manifested in the course of interview.

G14 Poor impulse control [_]
Disordered regulation and control of action on inner urges, resulting in sudden, unmodulated, arbitrary, or misdirected discharge of tension and emotions without concern about consequences. Basis for rating: Behavior during the course of interview and reported by primary care workers or family.

G15 Preoccupation [_]
Absorption with internally generated thoughts and feelings and with autistic experiences to the detriment of reality orientation and adaptive behavior. Basis for rating: Interpersonal behavior observed during the course of interview.

G16 Active social avoidance [_]
Diminished social involvement associated with unwarranted fear, hostility, or distrust. Basis for rating: Reports of social functioning by primary care workers or family.

APPENDIX IV

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	(**Note:** Use intermediate codes when appropriate, e.g., 45, 68, 72.)
100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
91	
90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
81	
80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument): No more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
71	
70	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
61	
60	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or coworkers).
51	
50	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
41	
40	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
31	
30	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
21	
20	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
11	
10	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
1	
0	Inadequate information.

APPENDIX V

V - Presumptive Stressful life events scale (Gurmeet Singh et al.,. 1983)

	Life Events	Mean stress Score
1.	Deaths of spouse	95
2.	Extra-marital relation of spouse	80
3.	Marital separation / Divorce	77
4.	Suspension or dismissal from job	76
5.	Detention in jail of self or close family member	72
6.	Lack of child	67
7.	Death of close family member	66
8.	Marital conflict	64
9.	Property or crops damaged	61
10.	Death of friend	60
11.	Robbery or theft	59
12.	Excessive alcohol or drug use by family member	58
13.	Conflict with in-laws (other than over dowry)	57
14.	Broken engagements of love affairs	57
15.	Major personal illness or injury	56

16.	Son or daughter leaving home	55
17.	Financial loss or problems	54
18.	Illness of family member	52
19.	Trouble at work with colleagues, Superiors or subordinates	52
20.	Prophecy of astrologer or palmist etc.	52
21.	Pregnancy of wife (wanted or unwanted)	52
22.	Conflict over dowry (self or spouse)	51
23.	Sexual problems	51
24.	Self or family member unemployed	51
25.	Lack of son	51
26.	Large loan	49
27.	Marriage of daughter or dependent sister	49
28.	Minor violation of law	48
29.	Family conflict	47
30.	Break-up with friend	47
31.	Major purchase or construction of house	46
32.	Death of pet	44
33.	Failure in examination	43

34.	Appearing for an examination or interview	43
35.	Getting married or engaged	43
36.	Trouble with neighbor	40
37.	Unfulfilled commitments	40
38.	Change in residence	39
39.	Change or expansion of business	37
40.	Outstanding personal achievement	37
41.	Begin or end schooling	36
42.	Retirement	35
43.	Change in working conditions or transfer	33
44.	Change in sleeping habits	33
45.	Birth or daughter	30
46.	Gain of new family member	30
47.	Reduction in number of family function	29
48.	Change in Social activities	28
49.	Change in eating habits	27
50.	Wife begins or stops work	25
51.	Going on pleasure trip or pilgrimage	20

APPENDIX VI

INSTITUTIONAL ETHICAL COMMITTEE
MADRAS MEDICAL COLLEGE, CHENNAI -3

Telephone No: 04425305301
Fax : 044 25363970

CERTIFICATE OF APPROVAL

To
Dr. M. Venkat Lakshmi
PG in MD Psychiatry
Institute of Mental Health
Kilpauk , Chennai -10.

Dear Dr. M. Venkat Lakshmi

The Institutional Ethical Committee of Madras Medical College reviewed and discussed your application for approval of the project / proposal / clinical trail entitled " A study on acute and transient psychotic disorder- diagnostic stability and clinical characteristics" No 55082010.

The following members of Ethical committee were present in the meeting held on 24.08.2010 conducted at Madras Medical College, Chennai -3.

1. Prof. S.K. Rajan, MD	-- Chairperson
2. Prof. J. Mohanasundaram, MD,Ph.D,DNB Dean, Madras Medical College, Chennai -3	-- Deputy Chairman
3. Prof. A. Sundaram, MD Vice Principal , MMC, Chennai -3	-- Member Secretary
4. Prof R. Nandhini, MD Director, Institute of Pharmacology, MMC, Ch-3	-- Member
5. Prof. C. Rajendiran , MD	-- Member
Director, Institute of Internal Medicine, MMC, Ch-3	-- Member
6. Prof. Md. Ali, MD, DM	-- Member
Professor & Head ,,Dept. of MGE, MMC, Ch-3	-- Member
7 Prof. Shantha Ravishankar, MD Professor of Neuro Pathology, MMC, Ch-3	-- Member
8. Tmt. Arnold Soulina	-- Social Scientist

We approve the trail to be conducted in its presented form.

Sd /. Chairman & Other Members

The Institutional Ethics Committee expects to be informed about the progress of the study, any SAE occurring in the course of the study, any changes in the protocol and patient information / informed consent and asks to be provided a copy of the final report

Member Secretary, Ethics Committee

APPENDIX VII

CONSENT FORM

I, the undersigned have been explained the following in the language I understand.

1. I have been explained about the nature and details of the study and I give my full consent to participate in it freely, without any bias or coerhion.
2. I understand the purpose of this study is to find further information regarding the clinical characteristics and diagnostic stability of acute and transient disorder.
3. The finding of this study can be used in a thesis or research paper.
4. Personal information will be kept strictly confidential

Name and signature of the patient

Name and Signature of the Doctor

Name and signature of Witness

APPENDIX VIII

PATIENT INFORMATION SHEET

As you know ATPD is a n illness which is characterized by an acute onset of psychiatric symptoms within a period of two weeks or less, and is associated with a good outcome. In this study we are investigating certain clinical characteristics and diagnostic stability of the illness with the help of certain questionnaires. We shall assess the social demographic features family psychopathology, presence of stressor, symptoms pattern and severity, global functioning and diagnostic stability. We will compare the diagnostic retain group with diagnosis changed group on the above variables at the end of three months follow up. We seek your concern to take part in this study. If you consent we will examine your symptoms and functioning by interviewing you in detail. These tests will take around 2 – 3 hours to complete. We will show you how the tests are done before taking the assessment. After understanding the nature of assessment if you choose not to undergo the test your decision is respected by us. Taking part in the study does not involve any risk to your health. Please be informed that you have the right to refuse to take part in the study at any point of time.

Signature of the patient :

Date:

Place:

APPENDIX IX

GENERAL DATA SHEET

Sl.No.	Age	Sex	Education	Background	social economic st	Marital Status	Occupation	ATPD/ other psych	Family history	Stressor	P1	P2	P3	P4	P5	P6	P7	PANNS P-Total	PANNS N-Total	PANNS G- Total	GAF Score	37. verbal affect	39. voices third person	56. overactivity	64.hostile irritability	78. poor emotional rappor
1	26	1	2	2	2	1	4	1	1	1	6	3	5	3	5	5	7	37	7	38	78	1	0	1	1	0
2	21	1	2	2	3	2	1	2	1	1	5	3	6	5	1	6	6	32	9	49	47	1	1	0	1	1
3	55	1	2	1	2	2	1	1	2	2	6	1	3	5	1	4	7	27	11	35	79	0	0	1	1	0
4	32	1	2	1	3	2	1	1	2	1	4	1	1	5	4	3	3	21	10	21	70	0	0	0	1	1
5	23	2	5	2	2	1	3	1	1	1	5	2	5	2	2	5	3	24	8	27	72	1	0	0	1	0
6	19	2	5	2	3	1	3	2	1	1	3	5	4	5	4	2	5	28	20	45	52	1	0	1	1	1
7	32	2	2	2	3	2	2	1	1	2	6	2	7	6	4	6	6	37	7	22	80	1	0	0	1	0
8	21	2	2	1	3	2	2	1	2	2	4	4	1	6	1	5	4	25	15	46	71	0	0	0	1	0
9	19	1	5	1	2	1	3	1	2	2	3	4	1	1	4	4	1	18	12	25	72	1	1	1	0	0
10	35	2	1	1	3	3	1	2	2	1	5	3	4	3	1	4	3	23	10	24	52	1	1	0	1	0
11	20	2	3	2	2	1	1	1	1	1	5	3	4	5	4	4	3	28	7	21	73	0	0	1	1	0
12	19	2	1	1	3	1	1	2	1	2	4	4	6	4	1	5	4	28	19	36	30	1	1	0	0	1
13	27	2	2	1	2	3	1	1	1	2	5	1	3	6	1	5	5	26	10	27	61	0	0	0	1	0
14	30	2	2	2	3	2	2	1	1	1	4	3	3	3	4	4	2	23	11	32	81	0	0	0	0	0
15	21	1	3	2	2	1	1	1	2	2	4	3	4	5	3	5	3	27	11	26	65	1	0	1	1	0
16	26	2	2	2	3	2	2	1	1	1	5	3	4	4	1	5	4	26	10	40	68	1	1	1	1	0
17	18	2	3	2	2	1	1	1	2	2	3	4	3	5	3	4	3	25	7	23	75	0	0	0	1	0
18	28	2	3	2	2	2	2	1	2	2	4	3	3	5	2	3	4	24	7	20	77	0	0	0	1	0
19	25	1	3	1	3	1	1	1	1	2	3	2	4	6	5	2	7	29	8	32	65	0	0	1	1	0
20	30	2	2	2	3	2	2	2	2	1	6	2	6	2	3	6	3	28	10	21	61	0	1	0	0	0
21	27	2	2	1	3	1	2	2	2	2	3	6	3	4	1	4	2	23	9	35	40	0	0	0	0	0
22	45	2	2	1	3	2	1	1	2	2	4	2	6	3	1	4	1	21	7	25	62	1	0	1	0	0
23	18	2	2	1	3	1	5	1	2	2	3	4	3	4	3	4	3	24	7	25	72	0	0	1	1	0
24	20	2	2	2	3	1	1	2	2	2	3	2	4	1	1	3	1	15	28	41	53	1	0	0	0	1
25	41	2	1	2	3	2	2	1	1	2	3	2	3	3	1	3	1	16	13	25	74	1	0	0	0	0
26	28	1	2	2	3	1	1	2	1	2	4	3	3	3	1	4	3	21	21	43	50	0	0	0	0	1
27	22	1	2	1	3	2	1	1	1	1	6	3	5	3	5	5	7	37	7	38	72	1	0	0	0	0
28	36	1	3	1	2	2	1	2	2	2	6	3	6	4	1	6	4	30	7	28	61	0	1	0	1	0
29	22	2	2	2	2	2	1	1	2	2	3	3	5	6	1	5	7	30	7	41	69	0	0	1	1	1
30	26	2	2	1	2	1	5	1	1	2	3	4	3	4	3	4	3	24	7	25	75	0	0	1	1	0
31	25	2	2	1	3	2	2	1	1	1	4	3	3	5	2	3	4	24	7	22	76	0	0	1	1	0
32	30	1	2	2	3	2	1	1	1	2	6	4	5	7	4	5	7	38	7	35	78	1	0	1	1	0
33	31	2	2	1	2	2	2	2	1	1	4	3	4	6	5	5	5	27	7	39	62	1	0	1	1	1
34	40	2	1	1	3	2	2	2	1	2	6	3	7	4	1	5	4	31	12	25	45	1	1	0	1	0
35	32	2	5	2	1	1	5	1	1	2	5	3	4	4	1	5	4	26	10	33	69	1	0	1	1	0
36	35	1	2	1	3	2	1	2	1	1	5	3	4	4	6	6	3	31	7	30	61	1	1	1	1	0
37	19	1	3	1	2	1	1	1	2	2	3	4	3	4	3	4	3	24	7	25	73	0	0	1	1	0
38	38	2	2	1	3	2	2	2	1	2	3	1	3	3	1	3	2	15	20	43	62	1	0	0	0	0
39	45	2	2	1	2	2	1	2	2	2	5	3	4	3	1	4	3	23	7	24	52	1	1	0	1	0
40	27	1	5	2	1	1	3	1	2	1	5	2	5	2	2	5	3	24	8	27	75	0	0	0	1	1
41	33	1	2	1	2	2	1	1	2	2	3	4	3	4	3	4	3	24	7	20	77	0	0	1	1	0
42	28	2	2	1	2	2	2	1	2	2	3	4	3	5	3	4	3	25	7	20	81	0	0	1	1	0
43	18	2	2	1	2	1	5	1	1	1	6	4	5	7	4	5	7	38	7	31	73	1	1	1	1	0
44	30	1	5	1	2	1	1	2	2	2	6	3	6	4	1	6	4	30	7	28	63	0	1	0	1	0
45	25	1	2	2	3	2	1	2	1	1	5	3	4	4	6	6	3	31	7	33	51	1	0	1	1	0
46	29	2	2	2	3	1	1	1	2	2	4	3	3	5	2	3	4	24	7	22	68	0	0	1	1	0
47	25	1	3	1	3	1	1	1	2	1	3	4	3	4	3	4	3	24	7	23	75	0	0	1	1	0
48	22	1	2	2	2	1	1	1	2	2	3	4	3	4	3	4	3	24	7	25	77	0	0	1	1	0
49	29	1	3	2	1	1	5	1	2	2	4	1	1	5	4	3	3	21	10	21	78	0	0	0	1	1
50	30	1	1	1	3	1	1	1	2	2	3	4	3	5	3	4	3	25	7	24	80	0	0	1	1	0

APPENDIX IX

GENERAL DATA SHEET

51	32	1	5	2	2	1	1
52	29	2	5	2	2	2	2
53	18	2	3	1	3	1	1
54	40	1	1	1	3	2	1
55	32	1	2	1	3	1	1
56	28	2	5	2	2	2	2
57	22	2	4	1	2	1	5
58	25	2	5	2	2	1	1
59	30	1	4	1	3	2	1
60	55	1	2	2	2	2	1

SCAAPS

		1. Worrying	2. Tension	3. LOA	4. Delatyed Sleep	5. early awakening	6.LOL	7. DEP MOOD	8. hopelessness	9.sucidal plan	10.self DEP thought	11. anergia	12. Diurnal	13.exp mood	14. Ideomotor pressure	15. grandiose ideas	16.irretability	17. social WD	18. phobia	19. OBS comp	20. Conversion	21. ideas of ref.	22. Loss of interest.	23. loss of initiative	24. ability to enjoy	25.difficulty in concentration	26. memory difficulties.	27.loss of energy	28. DE -real	29. DE - personal	30. changed perception	31. TH - insert	32. TH broadcast	33. TH - echo	34. TH block	35 TH being read	36. auditory non verbal	37. verbal affect	38. vioces - 2nd person	39. voices third person	40. diss-hallu	41.visual - hallu	42. DEL-control	43. DEL-reference	44. DEL-percutation	45. DEL - grandeous
1	ATPD GROUPS	1	1	1	1	1	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1	1
3		1	1	1	1	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0
4		1	1	0	0	0	0	1	0	0	0	1	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1	1
5		1	0	1	1	1	0	1	1	1	1	1	0	0	0	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	1	1	0	0	0	1	1	0
7		0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	1
8		0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
9		0	0	1	1	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0	0	1	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	1	1	1	0	0	0	1	1
11		0	0	0	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1
13		0	0	0	1	1	0	1	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0
14		0	1	1	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0
15		0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0
16		1	1	1	1	1	0	1	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	1	1	0
18		1	1	1	1	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0
17		0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0
19		0	0	0	1	1	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
22		1	0	0	1	0	0	1	0	1	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0
23		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
25		0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	0
27		1	1	1	1	1	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	1
29		0	0	1	1	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0
30		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
31		1	0	0	1	0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
32		0	1	0	1	1	0	1	0	1	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	1
37		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
40		1	1	0	0	0	0	1	0	0	0	1	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1	1
41		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
42		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
43		1	1	1	1	1	0	1	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	1	1
46		1	0	0	1	0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
47		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
48		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
49		1	1	0	0	0	0	1	0	0	0	1	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	1	1	1
33		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
35		1	1	1	1	1	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	1
2	Other psychosis	1	1	1	1	1	0	1	1	1	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	1	0	1	1	1	0	0	0	1	1	0
6		0	0	1	1	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1
10		1	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	1	1	0
12		1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	1	0
20		0	0	0	1	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0
21		1	0	1	1	1	0	1	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	1	0
24		1	0	1	1	1	0	1	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	0
26		0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
28		0	0	1	1	1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	1	1	0
34		1	1	0	1	1	0	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	1	0	0	0	1	1	0
44		0	0	1	1	1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	1	1	0
45		0	1	1	1	1	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1	1	0	0	0	1	1	1
36		0	1	1	1	1	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	1	1	1
39		1	1	0	1	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	1	1	0
38		1	1	1	1	1	0	1	0	1	0	0	0	0	0	0	1	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0
33		0	1	0	1	1	0	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1

0 - Absent **1 - Present**

SCAAPS

46. DEL religious	47. DEL- sexual	48. DEL -hyp0condi	49, DEL- guilt	50. other DEL	51. Disorentation	52. clouding of corns	53. diss state.	54. other	55. agitation	56. overactivity	57. retardation	58. stupor	59. HYS-behavious	60. Inappro beh.	61. anxiety	62. depression	63. elation	64.hostile irretability	65. suspicion	66. perplexity	67. lability of mood	68.blunter affect	69. apathy	70. slow speech	71. mute	72. pressure of speech	73. flyte of ideas	74. irrelavante speech	75. other observed disorders	76. lack of insight	77. autism	78. poor emotional rappor	79. poor intellectual rappor	80. sym reflecting stressful events
1	0	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	0	1	1
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1	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	1	1	0
1	0	1	0	0	0	0	0	0	1	0	0	0	1	1	0	1	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	0	1	0
1	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
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0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	0	1	0	0	0	0	0	0	0	1	0	1	0	0	1	0
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0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0
1	0	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	0	1	1
0	0	0	0	0	1	0	0	0	1	1	0	0	0	1	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	1	1	0
0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
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0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	1	1	1	0	0	0	0	0	1	0	1	0	0	1	0	0	1	0
0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
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0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
0	0	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1
0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1
0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
1	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	1	1	0
0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
1	0	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	0	1	1
0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	1	1	0	1	1	1
1	0	0	0	0	1	0	0	0	1	1	0	0	1	1	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	1	1	0
0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	1	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	0	1	0
0	0	0	0	0	1	0	0	0	1	0	1	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	1	1	1	1	0
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0	1	0	1	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	1	0	1	1	0
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0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0
0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0
0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	1	0	0	1	1	1	0	0	0	0	0	0	0	1	0	1	0	0	1	0
0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	0	1	0	1	0	1	0	0

0 - Absent **1 - Present**

SEX :

1. Male
2. Female

EDUCATION:

1. Illiterate
2. Primary
3. Middle
4. Secondary
5. Graduation

BACKGROUND

1. Rural
2. Urban

SOCIOECONOMIC STATUS:

1. Above average
2. Average
3. Below average

MARITAL STATUS:

1. Unmarried
2. Married
3. Widows

OCCUPATION:

1. Cultivator and laborer
2. Household work
3. Student
4. Business and Professional
5. Unemployed

ATPD/OTHER PSYCHOSIS:

1. ATPD
2. Other Psychosis

FAMILY HISTORY / STRESSOR :

1. Present
2. Absent

PANNS SCORING

1. Absent
2. minimal
3. mild
4. moderate
5. moderate severe
6. severe
7. extreme

SCAPPS SCORING:

0 – Absent
1 - Present