

## Phenomenological Variations in Person with ‘Acute and Transient Psychotic Disorder (Atpd: An Insight from India)

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### INTRODUCTION

**Definition: Acute and Transient Psychotic Disorders (ATPD)** represent a distinct group of psychotic disorders characterized by an acute onset (within two weeks), rapidly changing polymorphic symptoms, and typical schizophrenic features. In a substantial proportion of cases, the onset is associated with an identifiable acute stressor, and complete recovery usually occurs within two to three months <sup>[1,2]</sup>.

**Epidemiology:** The prevalence of ATPD has not been extensively studied. Available epidemiological data from Western countries suggest that ATPD affects approximately 3.9–9.6 individuals per 100,000 population <sup>[3,4]</sup>. Although precise epidemiological data from India are lacking, available reports indicate a higher prevalence, with acute and transient psychosis being nearly ten times more common in developing nations compared to developed ones <sup>[5]</sup>. This highlights a potential socio cultural influence on the manifestation and course of ATPD.

**History:** ATPDs are clinically diverse and phenomenologically vibrant, often presenting with unique, variable symptom patterns that distinguish them from classical schizophrenia or affective psychoses. Historically, such cases were not recognized as a separate diagnostic category. The conceptualization of ATPD began in the late 19th century when German psychiatrists introduced the term *akute primäre Verrücktheit*, later renamed *paranoia acuta* by Karl Westphal, who described it as “an acute form of paranoia with an outburst of perceptual hallucinations, consisting mostly of hallucinatory voices and delusions, with clouding of consciousness.” Subsequently, Meynert (1890) described similar states as *amentia*.<sup>[6,7]</sup> In the early 20th century, Freud’s psychoanalytical theory of psychosis further enriched the understanding of such acute psychotic presentations<sup>[8]</sup>.

**Nosology:** Throughout the 20th century, ATPD underwent **numerous nomenclatural transformations**, reflecting ongoing debates about its nature and boundaries. Various terms were proposed, including acute onset forms of schizophrenia (Bleuler, 1911), psychogenic psychosis (Wimmer, 1916), oneroid experiences (Meyer Gross, 1924), acute schizoaffective psychoses (Kasanin, 1933), schizophreniform states (Langfeldt, 1939), *bouffées délirantes* et psychoses hallucinatoires aiguës (Ey, 1954), and *cycloid psychoses* (Leonhard, 1961).<sup>[9]</sup> Despite the terminological diversity, the group was formally recognized in 1992 when the International Classification of Diseases, 10th Revision (ICD-10), categorized ATPD as a distinct class of psychotic disorders.

**Diagnostic Challenges:** Clinically, ATPD occupies an intermediate position between schizophrenia and affective psychoses. It is characterized by the presence of clinically significant but variable psychotic symptoms, abrupt onset (within two weeks), and short duration (one to three months). The onset is frequently preceded by stressful life events.<sup>[10]</sup> Despite receiving a distinct nosological status, the diagnostic stability of ATPD remains a matter of debate due to overlapping symptomatology with schizophrenia and mood disorders. Several longitudinal studies have demonstrated diagnostic shifts over time, most commonly toward schizophrenia or bipolar disorder.<sup>[11-15]</sup> Although acute onset and early remission are characteristic, they do not necessarily predict a favorable long-term outcome.<sup>3</sup>

In summary, ATPD remains a unique yet diagnostically unstable entity, with clinical and epidemiological features that continue to challenge conventional classifications of psychotic disorders. Ongoing research is essential to clarify its etiology, diagnostic boundaries, and prognostic factors<sup>[12,13,14,15]</sup>

Keeping in view the diagnostic complexity, instability, progression to other diagnostic entities and lack of proper epidemiological data and dearth of information especially from India, it becomes important to study the phenomenology of ATPD in Indian settings and to also study different stressors playing role in the onset of these disorders.

## **METHODOLOGY**

Ethical clearance for the study was obtained from the Institutional Ethics Committee and screening for eligible patients was done from amongst those attending Psychiatry OPD/IPD at Era's Lucknow Medical College as per inclusion and exclusion criteria. A total of 100 patients with confirmed diagnosis of Acute and Transient Psychotic Disorder (ATPD) as per ICD- 10 guidelines<sup>1</sup> were enrolled in the study. Demographic details such as age, gender, place of residence, religion, education, location of residence, occupation, type of family and monthly family income were noted. The patients were then assessed using Positive and Negative Syndrome Scale (PANSS) for assessment of psychotic syndromes.

### **1) Positive and Negative Syndrome Scale (PANSS)**

It is an inventory of 30- different symptoms based on the interview as well as reports of family members or primary care hospital workers. It was published in 1987 by Stanley Kay, Lewis Opler, and Abraham Fiszbein. <sup>[16,17]</sup> It is widely used in the study of antipsychotic therapy. The scale is known as the "gold standard" used for all assessments of psychotic behavioral disorders. The scale is divided into three subscales, namely positive scale, negative scale and general psychopathology scale.

## **STATISTICAL ANALYSIS**

The data was analyzed using Statistical Package for Social Sciences (SPSS) version 21.0. Data has been represented as frequencies (numbers) and proportions (percentages) and mean±standard deviation. Chi-square test was used to compare the qualitative data. Continuous data was compared using Independent samples 't'-test and ANOVA. A 'p' value less than 0.05 indicated a significant association.

## RESULTS

**Table 1:** Age and Gender Distribution of Cases Enrolled in the Study

| SN | Characteristic            | No./% of patients         |
|----|---------------------------|---------------------------|
| 1. | <b>Age</b>                |                           |
|    | 18-20 Years               | 26                        |
|    | 21-30 Years               | 34                        |
|    | 31-40 Years               | 21                        |
|    | 41-50 Years               | 10                        |
|    | 51-60 Years               | 9                         |
|    | Mean Age $\pm$ SD (Range) | 30.62 $\pm$ 11.79 (18-60) |
| 2. | <b>Gender</b>             |                           |
|    | Male                      | 40                        |
|    | Female                    | 60                        |
|    | Male:Female               | 0.67                      |

Age of patients ranged from 18 to 60 years. Majority of patients (60%) were  $\leq 30$  years of age. There were only 9% patients aged 51-60 years. Mean age of patients was 30.62 $\pm$ 11.79 years.

Majority of patients were females (60%) and 40% were males. Sex ratio was 0.67.

**Table 2** shows the demographic profile of the patients enrolled in the study.

**Table 2:** Distribution of cases according to their demographic profile

| SN | Characteristic            | No./% of patients |
|----|---------------------------|-------------------|
| 1. | <b>Place of residence</b> |                   |
|    | Rural                     | 70                |
|    | Urban                     | 30                |
| 2. | <b>Religion</b>           |                   |
|    | Hindu                     | 53                |
|    | Muslin                    | 47                |
| 3. | <b>Education</b>          |                   |
|    | Illiterate                | 28                |
|    | Primary                   | 13                |
|    | Junior                    | 16                |
|    | High School               | 16                |
|    | Intermediate              | 4                 |

|    |                                 |    |
|----|---------------------------------|----|
|    | Graduate and above              | 23 |
| 4. | <b>Location</b>                 |    |
|    | Lucknow                         | 12 |
|    | Other cities from Uttar Pradesh | 75 |
|    | Other states                    | 13 |
| 5. | <b>Occupation</b>               |    |
|    | Homemaker                       | 39 |
|    | Farmer/Unskilled labour         | 17 |
|    | Skilled labourer                | 4  |
|    | Private job/Clerk               | 4  |
|    | Shopkeeper/Business             | 18 |
|    | Student                         | 18 |
| 6. | <b>Type of family</b>           |    |
|    | Joint                           | 43 |
|    | Nuclear                         | 57 |
| 7. | <b>Monthly family income</b>    |    |
|    | ≤Rs 10,000                      | 63 |
|    | 10,001-15,000                   | 18 |
|    | 15,001-20,000                   | 17 |
|    | >20,000                         | 2  |

Majority of patients were rural residents (70%). A total of 30% were urban residents. The study sample was predominated by Hindus (53%). Remaining 47% were Muslims. Maximum number of patients were illiterate (28%) followed by those educated up to graduation or above (23%), junior school and high school (16% each), primary school (13%) and intermediate (4%) respectively. Only 12% patients were local residents of Lucknow, majority (75%) were from other cities of Uttar Pradesh and 13% were from other states. Maximum (39%) patients were homemakers, followed by shopkeepers/business owners and students (18% each), farmer/unskilled labours (17%) and skilled labours and private jobbers/clerks (4% each) respectively. Majority of patients were from nuclear family (57%). A total of 43% were from joint family. There was a dominance of patients from lower income families with 63% patients reporting monthly family income ≤Rs 10,000 followed by 10,001-15,000 (18%), 15,000-20,000 (17%) and >20,000/- (2%) respectively.

**Table 3:** PANSS Scores for Positive and Negative Domains

| SN                      | Characteristic                  | Mean  | SD   | Minimum | Maximum | % of patients with score >3 for the item |
|-------------------------|---------------------------------|-------|------|---------|---------|------------------------------------------|
| <b>Positive Domains</b> |                                 | 21.23 | 5.56 | 10      | 32      |                                          |
| 1.                      | Delusions                       | 4.01  | 2.09 | 1       | 6       | 68                                       |
| 2.                      | Disorganizations                | 1.60  | 1.17 | 1       | 4       | 18                                       |
| 3.                      | Hallucinations                  | 4.54  | 2.06 | 1       | 7       | 78                                       |
| 4.                      | Excitement                      | 1.20  | 0.59 | 1       | 3       | 0                                        |
| 5.                      | Grandiosity                     | 1.20  | 0.60 | 1       | 3       | 0                                        |
| 6.                      | Suspiciousness                  | 5.00  | 1.89 | 1       | 7       | 78                                       |
| 7.                      | Hostility                       | 3.68  | 1.49 | 1       | 6       | 78                                       |
| <b>Negative Domains</b> |                                 | 14.12 | 3.36 | 7       | 23      |                                          |
| 8.                      | Blunted affect                  | 1.41  | 0.85 | 1       | 4       | 5                                        |
| 9.                      | Emotional withdrawal            | 3.13  | 1.19 | 1       | 5       | 49                                       |
| 10.                     | Poor rapport                    | 1.96  | 1.37 | 1       | 5       | 24                                       |
| 11.                     | Social withdrawal               | 3.66  | 2.01 | 1       | 7       | 48                                       |
| 12.                     | Difficulty in abstract thinking | 1.11  | 0.31 | 1       | 2       | 0                                        |
| 13.                     | Lack of spontaneity             | 1.86  | 1.10 | 1       | 5       | 4                                        |
| 14.                     | Stereotyped thinking            | 1.00  | 0.00 | 1       | 1       | 0                                        |

For different positive domain items on PANSS, mean scores ranged from  $1.2 \pm 0.59$  (excitement) to  $5.00 \pm 1.89$  (suspiciousness). Clinically significant scores ( $>3$ ) on positive domains were observed in 5 out of 7 items, viz. hostility (78%), suspiciousness (78%), hallucinations (78%), delusions (68%) and disorganizations (18%) respectively. For items excitement and grandiosity, none of the patients had scores above clinically significant level ( $>3$ ). Overall mean scores for positive domain were  $21.23 \pm 5.50$ .

On negative domain, mean scores ranged from  $1.00 \pm 0.00$  (stereotype thinking) to  $3.66 \pm 2.01$  (Social withdrawal). Clinically significant scores ( $>3$ ) were observed for emotional withdrawal (49%), social withdrawal (48%), poor rapport (24%), blunted effect (5%) and lack of spontaneity (4%) respectively. Overall mean negative domain scores were  $14.12 \pm 3.36$ .

**Table 4:** PANSS Scores on General Domains

| SN                   | Characteristic               | Mean  | SD   | Minimum | Maximum | % of patients with score >3 for the item |
|----------------------|------------------------------|-------|------|---------|---------|------------------------------------------|
| 1.                   | Somatic concern              | 1.15  | 0.36 | 1       | 2       | 0                                        |
| 2.                   | Anxiety                      | 1.60  | 0.92 | 1       | 3       | 0                                        |
| 3.                   | Guilt feelings               | 1.46  | 1.06 | 1       | 5       | 5                                        |
| 4.                   | Tension                      | 1.47  | 0.82 | 1       | 3       | 0                                        |
| 5.                   | Mannerisms& posturing        | 1.41  | 0.96 | 1       | 4       | 9                                        |
| 6.                   | Depression                   | 1.80  | 0.98 | 1       | 3       | 0                                        |
| 7.                   | Motor retardation            | 1.46  | 1.02 | 1       | 6       | 5                                        |
| 8.                   | uncooperativeness            | 2.55  | 1.49 | 1       | 5       | 48                                       |
| 9.                   | Unusual thought content      | 1.42  | 1.07 | 1       | 5       | 11                                       |
| 10.                  | Disorientation               | 1.00  | 0.00 | 1       | 1       | 0                                        |
| 11.                  | Poor attention               | 2.39  | 1.12 | 1       | 4       | 18                                       |
| 12.                  | Lack of judgment and insight | 5.62  | 0.69 | 4       | 7       | 100                                      |
| 13.                  | Disturbance of volition      | 1.61  | 1.02 | 1       | 6       | 4                                        |
| 14.                  | Poor impulse control         | 2.47  | 1.16 | 1       | 5       | 24                                       |
| 15.                  | Preoccupation                | 1.58  | 0.93 | 1       | 4       | 5                                        |
| 16.                  | Active social avoidance      | 4.06  | 1.63 | 1       | 7       | 62                                       |
| Total General Scores |                              | 33.01 | 5.10 | 20      | 43      |                                          |

For general domain, mean scores ranged from  $1.00 \pm 0.00$  (Disorientation) to as high as  $5.62 \pm 0.69$  (Lack of judgement and insight). Clinically significant scores ( $>3$ ) were observed for items lack of judgement and insight (100%), active social avoidance (62%), Uncooperativeness (48%), poor impulse control (24%), poor attention (18%), unusual thought content (11%), mannerisms and posturing (9%), guilt feeling, motor retardation and preoccupation (5% each) and disturbance of volition (4%) respectively. Overall mean score for general domain were  $33.01 \pm 5.10$ .

## DISCUSSION

Acute and transient psychotic disorder (ATPD) is a relatively less described psychotic disorder that is characterized primarily by its brief duration. It is generally perceived to be an event triggered by an acute stressful life event affecting the psyche of the affected individual in such a way to be manifested in terms of a short-lived psychotic disorder. Only a few studies from India and abroad are available that try to describe the phenomenology of this disorder in order to provide adequate clinical data that can help in developing various concepts that could define this disorder in more detail. In present study we made an attempt to understand the phenomenology of 100 newly diagnosed cases with first episode of ATPD.

With respect to age and gender of the patients, in present study they were aged between 18 and 60 years. Majority of patients were aged  $\leq 30$  years (60%) and were females (60%). Mean age of patients was  $30.62 \pm 11.79$  years. As far as age is concerned, the findings of present study are similar to that of Shaltout *et al.* <sup>[18]</sup> who also reported the age of 75.9% of their patients to be  $\leq 40$  years, however, they reported a dominance of males (69%) while our study had a dominance of females (70%). On the other hand, Ranjan *et al.* <sup>[16]</sup> in their study reported the mean age of patients as 26.7 years which is slightly lower than that of present study but found both the genders to be equally distributed (50% each). With respect to age, this disorder tends to affect young population with mean age generally in third or fourth decade<sup>[10,19-28]</sup> and gender profile showing a changing trend from study to study, thus showing no particular gender predilection.<sup>[10,19-23]</sup> The mean age of patients in present study is close to that reported with a few other studies from India<sup>10,26-28</sup> that stated the mean age to be 30-32 years and also indicated a female dominance.

In present study, the demographic profile of patients was characterized by rural areas (70%), Hindus (53%), those educated below class 8 (57%), patients from other cities of Uttar Pradesh (75%), homemakers and students (57%), those living in nuclear family (57%) and those having monthly family income  $\leq$ Rs 10,000 (63%).

There is variability regarding demographic profile of ATPD patients in different studies depending upon the environment and type of facility. Shaltout *et al.* <sup>[29]</sup> in a study from Qatar where a lot of expatriates work reported the dominance of expatriates, married and skilled/unskilled workers. Compared to their study, in present study



although majority of patients are from other cities than where the study has been conducted but they cannot be termed as expatriates. Moreover, skilled/unskilled workers comprised only 21% of study population. The occupational profile of patients in present study was comparable to Ranjan *et al.* <sup>[30]</sup> who reported housewives to be the most common occupational group (33.3%). Moreover, they also reported dominance of those from rural areas (90%), nuclear family (63.3%) and low-socioeconomic strata. However, in their study majority of patients were educated up to lower secondary or secondary level (53.3%) whereas in present study majority of patients are educated up to class 8 only. A better educational profile of patients is also reported by some other studies too.

Among different Indian studies, a dominance of those from rural areas and lower/middle socioeconomic class similar to our study have been reported by Chakraborty *et al.* <sup>[24]</sup> who also showed the mean education of patients to be 7.11 years which is comparable to present study where majority of patients are educated up to class 8 only. Unemployment or low family income, low education, nuclear family and rural background have also been reported to be the features of majority of patients in some other study from India <sup>[10,26-28]</sup>

In fact, the profile of majority of patients with ATPD presented a picture of deprivation coupled with inability to communicate, share and resolve one's problems thus holding the demographic and socioeconomic factors to be risks for such events. In our society, women, particularly those in rural areas, belonging to lower socioeconomic class, living in a nuclear family and having low education often face stresses that they fail to share with others and hence these circumstances may lead to precipitation of a psychotic disorder.

In present study, severity of psychotic symptoms was assessed using positive and negative syndrome scale (PANSS). PANSS scores for positive and negative domains ranged from 10 to 32 and 7 to 23. Mean positive domain score was  $21.23 \pm 5.56$  out of a maximum possible score of 49 while mean negative domain score was  $14.12 \pm 3.36$  out of a maximum possible score of 49. PANSS General domain scores ranged from 20 to 43 with a mean of  $33.01 \pm 5.10$  out of a maximum possible score of 112. Compared to findings of present study, Stanley Kay and colleagues <sup>[17]</sup> in their study on patients with schizophrenia reported the mean scores for positive, negative and general domains to be 18.2, 21.01 and 37.74 for positive domain, negative domain and general domain respectively, thus showing the psychotic burden in positive domain to be higher than that observed by them whereas for negative and general domain the burden was slightly lower than that observed by them. Among different positive domain

symptoms, suspiciousness, hostility and hallucinations were most common (78% each) followed by delusions (68%) and disorganization (18%) respectively. In present study, none of the patients had positive domain symptoms of excitement and grandiosity. On the other hand, in negative domain symptoms emotional withdrawal (49%) and social withdrawal (48%) were most common followed by poor rapport (24%), blunted affect (5%) and lack of spontaneity (4%) respectively. None of the patients had symptoms domain of difficulty in abstract thinking and stereotyped thinking. On general psychopathology domain lack of judgment and insight (100%) was the most common symptom followed by active social avoidance (62%), uncooperativeness (48%), poor impulse control (24%), unusual thought content (11%), mannerisms and posturing (9%), motor retardation, guilt feeling and preoccupation (5% each) and disturbance of volition (4%) respectively. None of the patients had general domain symptoms of somatic concern, anxiety, tension, depression and disorientation. Compared to present study, Esan and Fawole<sup>[20]</sup> in their study reported disorganization (66.1%), delusions (62.1%), hallucinatory behavior (49.2%), hostility (35.5%), excitement (17.7%), grandiosity (12.1%) and suspiciousness (6.5%) respectively, thus showing all the positive domain symptoms to be present. They also reported poor sleep in >70% of patients. On general domain they reported anxiety (35.5%), poor attention (47.6%), poor impulse control (33.9%) and poor judgement and insight (63.7%) as the common symptoms. Loya *et al.* <sup>[19]</sup> too reported delusions, hallucinations, disorganized behavior, speech and negative symptoms as the typical psychotic symptoms observed. The pattern of symptoms reflected in different studies shows variability, however, symptoms like hallucination, disorganization, delusions and hostility are some of the commonly observed symptoms in almost all the studies. The pattern of symptoms in different studies could be dependent on the psychosocial milieu of the patients and their environment. In present study, most of the patients are female from lower-socioeconomic status who are less educated and living in a nuclear family. It seems that owing to lack of communication and absence of a trustworthy partner with whom they could share their stresses the symptoms like suspiciousness, hostility and hallucinations emerged as the commonest symptoms. Emergence of negative domain symptoms like withdrawal and social withdrawal as the most common symptoms also indicated lack of trust among patients. On general domain too, social avoidance and uncooperativeness indicated the tendency of patients to be cut-off from social contacts.

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