CASE REPORT

Attenuated Psychosis

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Abstract

Attenuated psychosis syndrome is an entity that has recently been recognized in diagnostic and statistical manual of mental disorders-5th edition (DSM-5) as a condition for further study. It is a condition in which the patient experiences psychotic-like symptoms but it does not fulfill the criteria for a full-blown psychosis. We hereby present a possible case of attenuated psychosis in a 30-year-old female and discuss its implications in diagnosis and management.

Keywords: Attenuated psychosis, DSM 5, Prodrome.

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Introduction

Attenuated psychosis syndrome (APS) is a topic of controversy since its introduction in diagnostic and statistical manual of mental disorders-5th edition (DSM-5) as a new category. Even though prodromal symptoms of schizophrenia have long been recognized, they had no place in the classification system. Now introduction of a new category may improve early detection and treatment with the aim of reducing chronicity and long-term disability.[1] The DSM-5 provides proposed criteria only and no discrete criteria for this. The definition provided is "psychotic like symptoms that are below a threshold for full psychosis." Manual mentions these symptoms are in less severity, more transient, and with relatively good insight but associated with clinically significant distress or impairment in social, occupational, or other areas of functioning. The future risk of a full-blown psychotic disorder among these individuals is a major area of research now.

Case Description

A 30-year-old unmarried female, youngest of the five sisters, postgraduate by education, from semiurban background with middle-class socioeconomic status, presented with total duration of illness (TDI) of 1 year, with complaints of (c/o) decreased interaction with family members, irritability even with trivial things and aggressive spells, suspiciousness on family members, decreased work performance, and sleep disturbances. She was apparently normal 1 year back, interacting good with family members and friends even though she was not good at initiating conversations. Since 1 year, her interaction with family members declined in the form of avoiding conversations, not replying even after questioning, being confined to her room, and even taking food in her room alone. This behavior worsened over the time and created distress within the family; for example, they cannot take decisions on her marriage and future prospects as she is not answering any. She was becoming more irritable even with trivial things like candid interactions and showing some aggressive spells intermittently. She was also feeling low some times. She also had suspiciousness over family members that they are plotting against her and talking about her and her behavior in private but this suspiciousness is not persistent and lasts for 2 weeks maximum at a stretch. Her work performance also decreased over the time significantly with even not assisting in household chores that she was doing previously. She also had c/o sleep disturbances in the form of difficulty in initiation and maintenance. Since 2 weeks, these symptoms had increased in severity with suspiciousness and she confined herself to her room; hence, her parents thought of medical assistance. There was no history of (h/o) significant head injury/substance abuse/hearing voices/suicidal behavior/repetitive intrusive thoughts. In the past, she had one transient psychotic episode of 10 days' duration with c/o suspiciousness, aggressive spells, and irritability, which was subsided without any intervention. There was no h/o medical/surgical comorbidities. There was nil significant family history. Premorbidly well adjusted and able to do things. On examination (O/E), vitals were stable with mild pallor noted. On mental status examination (MSE), she was partially cooperative, psychomotor activity—decreased, mood—fine, affect—dull, thought—fleeting delusions, no perceptual abnormality, and impaired personal and social judgment with poor insight. Anxious features were noted on diagnostic psychometry.

Proposed Diagnostic Criteria for Attenuated Psychosis[2]

- At least one of the following symptoms are present in the attenuated form with sufficient severity and/or frequency to warrant clinical attention:
  - Delusions/delusional ideas
  - Hallucinations/perceptual abnormalities
  - Disorganized speech/communication
- Symptoms in criterion A must be present at least once per week for the past month.
- Symptoms in criterion A must have begun or worsened in the past year.

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- Symptoms in criterion A are sufficiently distressing and disabling to the individual and/or legal guardian to lead them to seek help.
- Symptoms in criterion A are not better explained by any other DSM-5 diagnosis, including substance-related disorders.
- Clinical criteria for a psychotic disorder have never been met.

Discussion

I am reporting this case in view of clinical diagnosis and management difficulties and rarity in presentation. Not meeting diagnostic criteria for any other psychotic disorder in DSM-5 but significant distress causing psychopathology leads us to the diagnosis of APS, which is the "condition for the further study" currently. Attenuated psychosis syndrome individuals are more impaired, showing a complex entanglement with a broad range of psychiatric symptoms and disorders, including depression, impulse control, and especially emerging personality disorders according to some studies.[3] Early diagnosis and treatment of such individuals may decrease chronicity and long-term disability. But treatment part, especially treating with anti-psychotics in absence of persistent psychotic symptoms, might need further discussion. Attenuated psychosis syndrome as a diagnostic category and its similarities and differences with psychosis risk syndrome and schizotypal personality disorders need further study.[4]

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