CASE REPORT

Brief Psychotic Disorder

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Abstract

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), short psychotic disorder is the sudden start of psychotic behavior that should last only around 1 month and is followed by complete remission with a chance of recurrence in the future. The factors that cause brief psychotic disorder (BPD) might be hereditary, neurological, or environmental. It was discovered that 0.05% of people had a BPD. Clinical symptoms include delusion, cognitive difficulties, hallucinations that alter perception, distorted speech, altered moods, altered behavior, and lack of insight. The diagnoses were made using the DSM-V and DSM-IV-TR categorization systems. Psychotherapy and pharmacological treatment are the mainstays of the treatment.

Keywords: Brief psychotic disorder, Pharmacological treatment, Psychotherapy, Remission.

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Introduction

A BPD is a psychiatric disorder characterized by symptoms that include hallucinating behavior, delusional thought, disorientation, disorganized speech, and delirious behavior.[1] As the name implies, these symptoms might persist for a day or up to a month. The symptoms may appear serious enough to the patient that they may provoke aggressive behavior or raise their risk of suicide. Since complete remission must occur within 1 month, the diagnosis is frequently anticipatory or retroactive.[2]

Case Description

A 17-year-old male presented with 1.5 months duration of illness that was abrupt in onset, continuous in course, and without any particular stressors. He was admitted with the complaints of suspicious about his mother trying to kill him, irritability, not willing to take prescribed medication, decreased appetite, and difficulty in initiating sleep for the past 1.5 months. The client received treatment at a private hospital for similar concerns that they had previously reported. Following the therapeutic plan, his condition has become better.

History Collection

Due to an overprotective family (i.e.), his father does not like him to be in the company of other boys and does not let him go out and be with his friends or play sports. So, he is detached from social life and prefers to stay at home and be on his own.

Mental Status Examination and Physical Examination

The patient had increased psychomotor activity, rapport established very difficult, delusion of persecution, worried mood, anxious effect, personal judgment, and test judgment was not intact and no insight (complete denial of illness with grade 1/6). In physical examination, no abnormal findings were present for the client and vital signs are stable (temperature – 98.6°F, pulse – 80 beats per minute, respiration – 20 breaths per minute, and blood pressure – 120/80 mm Hg).

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Investigation

Blood urea – 34 mg/dL, creatinine – 1.34 mg/dL, sodium – 133 mEq/dL, potassium – 4.6 mEq/dL, hemoglobin – 16 gm%, red blood cell (RBC) – 5.55 million cubic mm, platelets – 2.39 lakhs cubic mm, and white blood cell (WBC) – 8400 microliters.

Impression

Based on DSM-IV-TR and DSM-V classification: Axes-I and -II categories and code, the patient was diagnosed as 298.8 – Brief Psychotic Disorder.

Treatment

The client received antipsychotic-like tablet risperidone 1 mg one's in a day (OD) in the morning and 2 mg OD in the night, benzodiazepine-like tablet clonazepam 0.5 mg OD in the night, and tablet lorazepam 2 mg sedation optimisation strategy (SOS), anticholinergic-like tablet pacitane 2 mg OD in the morning. Following this, the patient attended many psychotherapies, like individual and family therapy, group counseling, cognitive behavior therapy, and video-recorded self-observation techniques. The patient's health

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became better, and he scooped up some adaptable behaviors and strengthened his defense strategies. The nursing practice plan was centered on the patient's main priorities, and he was kept under supervision in administering medicine, intravenous treatment, suitable diet, and different therapies were aided. At the time of discharge, the patient and family received information about drug compliance, rehabilitation centers, and the value of continued treatment.

Follow-up

- After 15 days, the patient was discharged.
- The patient's physical, mental, and ability to carry out daily tasks have all improved.
- Attending counseling and therapy sessions on a regular basis with a visit scheduled for 1 week later.

Discussion

It is an abrupt but transitory disease characterized by the emergence of one or more psychotic symptoms such as delusion, hallucination, incoherent speech, highly disorganized, or catatonic behavior. Traumatizing or stressful incidents may be the root problem for a BPD. There might be a hereditary, neuronal, or social factor for BPD-specific trigger by external stress such as traumatic events or accidents.[3,4] The treatment includes antipsychotic-like tablet risperidone 1 mg OD in the morning and 2 mg OD in the night, benzodiazepine-like tablet clonazepam 0.5 mg OD in the night and tablet lorazepam 2 mg SOS, anticholinergic-like tablet pacitane 2 mg OD in the morning. Following this, the patient attended many psychotherapies like individual and family therapy, group counseling, cognitive behavior therapy, and video-recorded self-observation techniques.

Nursing Implications

- Family and patient education is a key part of psychotherapy interventions for BPDs. It needs the collaborative efforts of a strong effective interprofessional that comprises the general practitioner, psychiatric nurse practitioner, psychologist, and psychiatrist.
- The importance of developing and implementing a patient-centered approach with an emphasis on psychotherapy and medicine is underscored by the potential disruption that a disease process may cause for the client and their family.
- By focusing on the biopsychosocial aspect of well-being, one may help to lessen the overall negative effects of this condition on the person's life and functioning while also ensuring that the patient is given the right assistance everywhere.

Declaration of Patient Consent

The authors attest that they have secured all necessary patient permission documents. The patient has consented on the forms, along with additional clinical data that will be included in the journal. The patient is aware that his surname and initials would not be published, and while every effort will be taken to keep his identity a secret, complete confidentiality cannot be secured.

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