Case Report

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Brief psychotic disorder: when should antipsychotic treatment be discontinued? A case report

Transtorno psicótico breve: quando suspender o antipsicótico? Relato de caso

Trastorno psicótico breve: ¿cuándo suspender el antipsicótico? Reporte de caso

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ABSTRACT:

Introduction: The duration of antipsychotic treatment after remission from a first episode of psychosis remains debated, and direct extrapolation from schizophrenia protocols to brief psychotic disorder requires caution. **Objective**: To discuss early antipsychotic discontinuation in a case of brief psychotic disorder with catatonic symptoms, considering differential diagnosis, functional recovery and the literature on first-episode psychosis. **Method**: Case report supported by a narrative literature review on brief psychotic disorder, catatonia, early intervention in psychosis and maintenance, dose-reduction or discontinuation strategies for antipsychotics. Research Ethics Committee of Military Police Hospital, under opinion number 8.362.020, CAAE 195790526.5.0000.0283. Submitted signed Informed Consent Form. **Result**: A man younger than 25 years presented with an acute first episode of psychosis, including persecutory and guilt-related delusions, disorganized thought, postural rigidity, fixed gaze, reduced verbal spontaneity and psychomotor behavior compatible with catatonia. Initial clinical and neurological investigation did not identify an organic cause. He responded rapidly to lorazepam and risperidone, with remission of psychotic, catatonic and apparent negative symptoms. Antipsychotic medication was gradually discontinued early because of functionally relevant adverse effects, and approximately one year of outpatient follow-up showed no relapse. **Conclusion**: In brief psychotic disorder, antipsychotic discontinuation should be individualized, longitudinally reassessed and accompanied by close monitoring, particularly when catatonia, negative symptoms, diagnostic uncertainty or treatment-related functional impairment is present.

Keywords: antipsychotics, treatment discontinuation, psychosis, psychotic disorders, catatonia, first-episode psychosis, brief psychotic disorder

RESUMO:

Introdução: A duração do tratamento antipsicótico após remissão de um primeiro episódio psicótico é objeto de debate, e a extrapolação direta de protocolos de esquizofrenia para o transtorno psicótico breve exige

cautela. **Objetivo**: Discutir a suspensão precoce de antipsicótico em um caso de transtorno psicótico breve com sintomas catatônicos, considerando diagnóstico diferencial, evolução funcional e literatura sobre primeiro episódio psicótico. **Método**: Relato de caso com apoio de revisão narrativa de literatura sobre transtorno psicótico breve, catatonia, intervenção precoce em psicose e estratégias de manutenção, redução ou descontinuação de antipsicóticos. Parecer do Comitê de Ética em Pesquisa do Hospital da Polícia Militar, CAAE 1 95790526.5.0000.0283, Parecer 8.362.020. Enviou TCLE assinado. **Resultado**: Homem com menos de 25 anos apresentou primeiro episódio psicótico de início agudo, com ideias persecutórias e de culpa, desorganização do pensamento, rigidez postural, olhar fixo, redução da espontaneidade verbal e comportamento psicomotor compatível com catatonia. A investigação clínica e neurológica inicial não identificou causa orgânica. Houve resposta rápida a lorazepam e risperidona, com remissão de sintomas psicóticos, catatônicos e negativos aparentes. A retirada gradual do antipsicótico foi realizada precocemente devido a efeitos adversos funcionais, com seguimento ambulatorial por cerca de um ano sem recaída. **Conclusão**: Em transtorno psicótico breve, a decisão de suspender antipsicótico deve ser individualizada, longitudinal e acompanhada de monitoramento rigoroso, especialmente quando há catatonia, sintomas negativos, dúvida diagnóstica ou prejuízo funcional associado ao tratamento.

Palavras-chave: antipsicóticos, interrupção do tratamento, psicose, transtornos psicóticos, catatonia, primeiro episódio psicótico, transtorno psicótico breve.

RESUMEN:
Introducción: La duración del tratamiento antipsicótico después de la remisión de un primer episodio psicótico sigue siendo objeto de debate, y la extrapolación directa de protocolos de esquizofrenia al trastorno psicótico breve requiere cautela. **Objetivo**: Discutir la suspensión precoz del antipsicótico en un caso de trastorno psicótico breve con síntomas catatónicos, considerando el diagnóstico diferencial, la recuperación funcional y la literatura sobre primer episodio psicótico. **Método**: Informe de caso respaldado por una revisión narrativa de la literatura sobre el trastorno psicótico breve, la catatonía, la intervención temprana en psicosis y las estrategias de mantenimiento, reducción de dosis o suspensión de antipsicóticos. Aprobado por el Comité de Ética en Investigación del Hospital de la Policía Militar dictamen n. 8.362.020; CAAE 195790526.5.0000.0283. Se presentó el formulario de consentimiento

informado firmado. **Resultado**: Varón menor de 25 años presentó un primer episodio psicótico de inicio agudo, con ideas persecutorias y de culpa, desorganización del pensamiento, rigidez postural, mirada fija, reducción de la espontaneidad verbal y comportamiento psicomotor compatible con catatonía. La investigación clínica y neurológica inicial no identificó una causa orgánica. Respondió rápidamente a lorazepam y risperidona, con remisión de síntomas psicóticos, catatónicos y negativos aparentes. El antipsicótico se suspendió gradualmente de forma precoz debido a efectos adversos funcionalmente relevantes, y el seguimiento ambulatorio de aproximadamente un año no mostró recaídas. **Conclusión**: En el trastorno psicótico breve, la suspensión del antipsicótico debe ser individualizada, longitudinal y acompañada de seguimiento estrecho, especialmente cuando existen catatonía, síntomas negativos, incertidumbre diagnóstica o deterioro funcional relacionado con el tratamiento.

Palabras clave: antipsicóticos, interrupción del tratamiento, psicosis, trastornos psicóticos, catatonía, primer episodio psicótico, trastorno psicótico breve.

INTRODUCTION

Brief psychotic disorder is defined in DSM-5-TR by the presence of one or more psychotic symptoms, delusions, hallucinations, disorganized speech or grossly disorganized/catatonic behavior, lasting at least one day and less than one month, followed by full return to the premorbid level of functioning [1]. The category is clinically useful but requires caution: at the onset of psychosis, the diagnosis may change during longitudinal follow-up, particularly when catatonic symptoms, negative symptoms, affective symptoms, substance use, medication effects or neurological and medical causes are possible [1 - 2].

First-episode psychosis is a syndromic and service-oriented formulation, not a single diagnosis. Several international programs and guidelines organize early care around this concept, including comprehensive assessment, early intervention, family psychoeducation, risk monitoring, substance-use management, functional rehabilitation and pharmacological treatment when indicated [3 - 4]. However, evidence on the duration of maintenance antipsychotic treatment after remission comes mainly from schizophrenia, schizophreniform disorder and recent-onset non-affective psychosis, rather than specifically from brief psychotic disorder [2, 5 - 6].

This distinction matters because brief psychotic episodes have

heterogeneous trajectories. Recent reviews show that some patients achieve sustained remission, whereas others experience recurrence, diagnostic transition or poorer outcomes, particularly when duration of untreated psychosis is longer, negative symptoms are present, functional impairment persists, cannabis use occurs or markers of psychosis vulnerability are identified [2, 7]. Therefore, the question of when to discontinue antipsychotic treatment should be answered according to the most likely diagnosis, relapse risk, tolerability, functional recovery, family support and the feasibility of close follow-up.

This case report describes brief psychotic disorder with catatonic symptoms, psychiatric hospitalization, rapid response to lorazepam and risperidone, and early antipsychotic discontinuation because of functionally relevant adverse effects, with favorable outcome after approximately one year of follow-up. The aim is to discuss the limits of extrapolating first-episode psychosis protocols to brief psychotic disorder and the precautions required when reducing or discontinuing antipsychotics.

METHOD

This is a case report supported by a narrative literature review on brief psychotic disorder follow-up from acute hospitalization to outpatient care. Research Ethics Committee of Military Police Hospital, under opinion number 8.362.020, CAAE 195790526.5.0000.0283. Submitted signed Informed Consent Form. Potentially identifying data were grouped or omitted to preserve confidentiality, including exact age, place of origin, religion, specific training institution, specific role performed during the course and subsequent academic details.

Ethical considerations

As informed by the authors, this case report is part of a protocol approved by a Research Ethics Committee, with documentation retained by the authors for submission to the journal if requested. Patient confidentiality was protected through anonymization, grouping and omission of potentially identifying information.

A directed narrative review was conducted on brief psychotic disorder, first-episode psychosis, catatonia and strategies for antipsychotic maintenance, dose reduction or discontinuation. Recent reviews, guidelines, randomized clinical trials, follow-up studies and population-based cohorts were prioritized, with attention to the distinction between evidence specific to brief psychotic disorder and evidence extrapolated from non-affective psychosis or recent-onset schizophrenia.

Case presentation

A man younger than 25 years, single and a student, with no known personal psychiatric history and no reported family history of psychiatric disorders, has been followed as an outpatient for approximately one year after hospitalization for a first episode of psychosis. Before the episode, he was enrolled in a training course with high physical and intellectual demands.

The following description retrospectively reconstructs the presentation of the first episode. According to collateral information and medical records, behavioral change was perceived acutely during the course. The exact duration of the initial period, in days or weeks, could not be reliably determined from the available information; therefore, the term acute onset is used to indicate a clinically evident change within a short interval, perceived by colleagues and relatives, rather than to establish a precise duration.

On admission, the clinical picture was compatible with a first episode of psychosis, with persecutory delusions directed toward colleagues, guilt- and ruin-related ideas, self-referential interpretations of the gaze and behavior of others, disorganized thought and socially inappropriate behavior. Catatonic symptoms were also present: postural rigidity, fixed and poorly responsive gaze, reduced verbal spontaneity, response latency, ocular stereotypy, apparent perplexity/discomfort during the interview and abrupt interruptions of verbal contact. There was no consistent history of a major depressive episode, mania or hypomania preceding the psychotic episode.

Brain computed tomography and initial laboratory investigation did not reveal findings that explained the psychotic state. There was no known history of psychoactive substance use or medications associated with psychotic symptoms. Haloperidol was administered in the initial emergency setting to manage agitation and psychotic symptoms.

In the inpatient unit, lorazepam 2 mg/day was introduced, with rapid improvement of catatonic symptoms, and risperidone 2 mg/day was started, with remission of psychotic symptoms. A family member described the clinical course as a return to the premorbid pattern after a few days of treatment. The patient was discharged after approximately one week of hospitalization, with remission of psychotic and catatonic symptoms and without clinically evident persistence of negative symptoms such as affective flattening, avolition, alogia or social withdrawal.

Dose reduction was attempted because of functionally relevant adverse effects, especially psychomotor slowing, in a context of high cognitive and physical demands. Lorazepam was discontinued approximately one month after symptom onset, after resolution of catatonia. Risperidone was reduced to 1 mg/day at the same time and discontinued approximately 20 days later after a new clinical assessment. The patient remained in outpatient follow-up for approximately one year without recurrence of psychotic, catatonic, affective or behavioral symptoms, with functional recovery and maintenance of academic and social activities.

DISCUSSION

This case illustrates a common clinical situation: a first episode of psychosis with acute onset and sufficient severity to require hospitalization, but with rapid remission and sustained functional recovery. Brief psychotic disorder was favored by duration shorter than one month, full recovery, absence of known previous psychiatric history, absence of syndromic affective symptoms, absence of substance use or identifiable organic cause and sustained remission during approximately one year of follow-up [1 - 2].

The differential diagnosis with schizophrenia with catatonia or schizophreniform disorder with catatonia should be explicit. Catatonia does not by itself define schizophrenia; it can occur in psychotic disorders, mood disorders, neurological and medical conditions, and substance- or medication-induced states [1, 8]. In the present case, short duration, complete remission, absence of persistent negative symptoms and sustained functional recovery make schizophrenia less likely at this point. Nevertheless, the diagnostic formulation should remain longitudinal because some initially brief episodes may evolve into other diagnoses over time [2].

The literature on first-episode psychosis supports coordinated care, early intervention and intensive follow-up. Trials and pragmatic studies such as the RAISE Early Treatment Program/NAVIGATE indicate benefits of multidisciplinary approaches on functioning and quality of life [4]. Early-intervention studies such as OPUS also support integrated treatment, family psychoeducation and psychosocial support in early psychosis [9]. However, these protocols organize care for early psychosis in general and do not by themselves determine the optimal duration of antipsychotic treatment in brief psychotic disorder.

Antipsychotic maintenance after remission reduces relapse risk in schizophrenia and in samples of first-episode psychosis, but the

applicability of these data to brief psychotic disorder is limited. Trials of dose reduction or discontinuation in first-episode psychosis have shown heterogeneous results. Wunderink et al. found that an early dose-reduction/discontinuation strategy increased short-term relapse but was associated with higher functional recovery at 7-year follow-up compared with maintenance treatment [10]. In contrast, a 10-year randomized follow-up in first-episode schizophrenia and related disorders found poorer clinical outcomes in patients assigned to early discontinuation, supporting greater caution in schizophrenia-spectrum psychoses [11].

Observational data also reinforce caution in early discontinuation for schizophrenia. A nationwide 20-year cohort of first-episode schizophrenia found a higher risk of treatment failure after antipsychotic discontinuation, even after years of treatment [12]. These findings do not preclude discontinuation in selected cases of brief psychotic disorder; rather, they indicate that brief remitting episodes should be distinguished from psychoses with higher risk of chronic course.

Ideally, antipsychotic reduction after remission should be gradual, planned and shared with the patient and family. Clinicians should verify symptomatic and functional stability, absence of persistent negative symptoms, absence of substance use, good insight or adherence to follow-up, family support, low suicide or aggression risk and rapid access to care if early signs of relapse emerge [5, 6, 13]. For first-episode psychosis in general, guidelines commonly recommend maintenance treatment for at least 12 months after remission, and specialized services often consider longer periods when schizophrenia, residual symptoms, poor adherence, cannabis use, multiple admissions or incomplete functional recovery are present [5, 6, 13].

When discontinuation is chosen, the literature favors gradual reduction, frequent monitoring and an explicit relapse-prevention plan. Although no universal protocol exists, a prudent approach includes stepwise reduction, regular clinical reassessment, education about prodromal signs, a plan to restart treatment if insomnia, suspiciousness, withdrawal, disorganization, catatonic symptoms or functional deterioration occurs, and involvement of authorized family members [5, 6, 13]. In the present case, discontinuation was earlier than recommended for most first-episode psychosis presentations; its clinical rationale was relevant functional impairment associated with medication, in the context of complete remission and close follow-up.

Catatonia adds complexity to management. Recent guidelines recommend active recognition of catatonic signs, investigation of medical and neurological causes, benzodiazepines as first-line treatment in many cases and electroconvulsive therapy when symptoms are refractory, severe or associated with medical risk [8]. In this case, rapid response to lorazepam supported the syndromic diagnosis of catatonia and allowed discontinuation after resolution. The absence of recurrent catatonia during follow-up is favorable but should continue to be monitored.

Limitations include the single-case design, absence of standardized psychometric instruments for catatonia, psychosis and negative symptoms, inability to precisely reconstruct the duration of the initial presentation and lack of a comparison group. Still, the report is clinically relevant because it details early antipsychotic discontinuation after severe brief psychotic disorder with catatonia, full remission and sustained functional recovery. Future studies should evaluate, in larger samples, which patients with brief psychotic episodes may benefit from early medication reduction without unacceptable relapse risk.

CONCLUSION

The optimal duration of antipsychotic maintenance after brief psychotic disorder remains insufficiently defined. Evidence from first-episode psychosis provides useful parameters but should be applied cautiously when the presentation fulfills criteria for brief psychotic disorder and complete remission occurs. In the present case, early discontinuation was successful after approximately one year of follow-up, but this approach should not be generalized without individualized assessment.

The decision to reduce or discontinue antipsychotic treatment should consider differential diagnosis, episode duration, catatonia, negative symptoms, functional recovery, tolerability, patient preference, family support and the feasibility of close monitoring. The main contribution of this report is to emphasize that discontinuation may be considered in selected cases, but only within a longitudinal formulation, with a clear monitoring plan and rapid reintervention if relapse signs appear.

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