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RESEARCH ARTICLE

# Diagnostic stability and predictive factors of acute and transient psychotic disorders: A naturalistic observational study

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**ABSTRACT**

**Objective:** This study aims to evaluate the diagnostic stability as well as the clinical and sociodemographic variables influencing diagnostic changes in patients diagnosed with acute and transient psychotic disorder (ATPD).

**Method:** A retrospective observational study was conducted at Gazi University Faculty of Medicine, Psychiatry Department. Sociodemographic and clinical data were collected, including age, gender, marital status, education, employment status, duration of symptoms, hospitalization history, substance use, and pre-diagnostic stressors. Multivariate logistic regression analysis was employed to identify independent predictors of diagnostic change.

**Results:** A total of 106 patients (57 males, 49 females) with a mean age of 29.90±10.33 years were included in the study. The diagnostic stability of ATPD was observed in 17.8% of cases. Over a three-year follow-up period, 62.3% of patients were diagnosed with schizophrenia and other psychotic disorders. Significant differences between diagnostic groups were found in terms of education ($\chi^2$=9.776, p=0.008) and hospitalization ($\chi^2$=8.083, p=0.018). Multivariate logistic regression analysis revealed that younger age at onset (odds ratio [OR]=0.951, 95% confidence interval [CI] 0.90–0.96; p=0.032) and lower educational level (OR=0.219, 95% CI 0.08–0.54; p=0.001) were significantly associated with a diagnostic shift to schizophrenia and other psychotic disorders.

**Conclusion:** The diagnostic stability of ATPD in Turkiye was found to be low, with most diagnostic changes shifting towards schizophrenia and related psychotic disorders. Lower educational status and younger age at onset were significant predictors of diagnostic change. These findings underscore the need for large-scale, prospective studies to better understand the factors influencing diagnostic stability and the roles of clinician attitudes and stigma in ATPD diagnosis.

**Keywords:** Acute and transient psychosis, acute and transient psychotic disorder (ATPD), diagnostic stability, schizophrenia

## INTRODUCTION

Diagnostic stability refers to the degree to which a psychiatric diagnosis remains consistent over time across subsequent clinical evaluations (1). It measures whether a diagnosis made at one point in time is reliable and enduring, rather than subject to change as more clinical information becomes available or as the disorder evolves. In the 10th edition of the International Classification of Diseases (ICD-10), acute and transient psychotic disorders (ATPD) are defined as a composite category that amalgamates traditional

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definitions of acute psychosis (2). Acute and transient psychotic disorder in ICD-10 is characterized by an acute onset (≤15 days) and rapid resolution (within one to three months), often associated with acute stressful life events (2). Conversely, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), defines a similar condition as "brief psychotic disorder (BPD)" but with some differences. While DSM-5 specifies the duration of symptoms to be at least one day but less than one month (3), ICD-10 requires the most severe period of symptoms to last less than two weeks, with recovery occurring within three months at the latest (2). Both guidelines describe similar psychotic symptoms; however, ICD-10 emphasizes the polymorphic nature of symptoms by presenting different subtypes. Additionally, ICD-10 does not specify whether symptoms are related to stress, whereas DSM-5 includes this distinction. Although ATPD and BPD can be considered similar categories, they only partially overlap due to differences in onset, duration, and symptomatology.

The incidence of ATPD ranges between 4 and 10 per 100,000 individuals, with a prevalence varying from 5.8% to 19% (4–6). It is more common in middle to older age groups and in females (5). Despite being generally considered a disorder with a good prognosis due to its short duration and rapid recovery, ATPD is associated with increased mortality due to the high risk of suicide (7–9).

One of the critical aspects of diagnosing ATPD is diagnostic stability. Several studies have reported diagnostic stability values ranging between 35.9% and 56% (6, 10–13). Factors contributing to this variability include age of onset, gender, comorbid substance use, the presence of similar characteristics in different diagnoses, failure to evaluate diagnoses longitudinally, and subthreshold symptoms (14). Long-term follow-up studies on the diagnostic consistency of patients presenting with first-episode psychosis indicate that the highest consistency is associated with a diagnosis of schizophrenia (6, 15, 16). In Turkiye, Ozturk et al. (17) found that in a five-year follow-up of 47 patients diagnosed with ATPD, all patients' diagnoses changed, with schizophrenia and non-organic psychosis being the most frequent follow-up diagnoses. In a meta-analysis conducted by Castagnini et al. (11) in 2022, the diagnostic stability of ATPD was reported to be 55%, with 25% of patients whose diagnoses changed receiving a diagnosis of schizophrenia and related disorders and 12% receiving a diagnosis of affective disorders. The same study reported a diagnostic stability of 45% for BPD (11). Another meta-analysis reported a diagnostic stability of 49% for BPD, with a recurrence rate of 15% within six months and noted that the recurrence rate increased to 33% when the follow-up period exceeded three years (12).

The results of studies investigating predictive factors in patients with diagnostic changes are inconclusive. Various studies have associated family history, early age of onset, male gender, and low premorbid functioning with conversion to schizophrenia and other non-affective psychosis (6, 18–20). The presence of schizophrenic symptoms and thought disorder at the time of diagnosis are also symptoms associated with transition to schizophrenia and related disorders (18, 21). Additionally, several studies have indicated that a prolonged duration of untreated psychosis (DUP), extended hospitalizations, the requirement for high doses of antipsychotics to manage symptoms, and the recurrence of psychotic episodes are variables potentially associated with an elevated risk of developing persistent psychotic conditions during follow-up (20, 22, 23).

This study investigates the diagnostic stability of ATPD over a three-year follow-up period, focusing on the clinical and sociodemographic factors influencing diagnostic changes. The objective of this study was to examine the diagnostic stability of ATPD, with the hypothesis that diagnostic stability would be low and that most diagnostic transitions would shift towards schizophrenia and related psychotic disorders. Additionally, we aimed to investigate whether any sociodemographic or clinical variables could serve as predictors for such diagnostic changes. Given the absence of prior studies on this topic in Turkiye, this research seeks to contribute valuable insights to the existing body of knowledge, particularly regarding diagnostic patterns and the factors influencing ATPD in our country.

## METHODS

### Study Design and Participants

This study was designed as a retrospective observational study conducted in the psychiatry clinic of a university hospital. The medical records of all patients aged 18–65 who were initially diagnosed with ATPD according to the ICD-10 codes F23.8 and F23.9 between 2008 and 2018 were reviewed. Researchers assessed diagnostic accuracy of each record. Patients whose history suggested substance-induced psychotic disorder, organic psychosis, or

intellectual disability, as well as those with a prior diagnosis of psychotic disorder, were excluded from the study despite meeting ICD-10 criteria for ATPD. Patients with other comorbid psychiatric disorders were not excluded. Among those meeting the diagnostic criteria for ATPD, patients without regular follow-up for at least three years or those lacking sufficient clinical and/or sociodemographic data were also excluded from the evaluation. The latest available psychiatric diagnosis was considered the final diagnosis. A total of 332 patients met the inclusion criteria. Of these, 196 patients did not have regular follow-up over three years, and 30 patients were excluded due to insufficient clinical data. The data of the remaining 106 patients were analyzed.

### Procedure

Following patient screening, a database was created consisting of sociodemographic characteristics such as age, gender, marital status (married or unmarried), education level (lower education or secondary/high education), and employment status (employed or unemployed). Clinical information, including duration of symptoms, past psychiatric history, hospitalization history at admission, history of alcohol and substance use prior to admission, family history of mental illness, and the presence of stressors in the pre-diagnostic period potentially related to diagnostic changes, was also recorded. The final diagnosis was determined based on the diagnosis at the final admission. Since this study was a retrospective evaluation and written consent was not obtained from the patients, all data were recorded anonymously in a data sheet without any personally identifiable information.

The study received ethics approval from the Ethics Committee of Gazi University (date: 11/07/2023, no: 2023-889).

### Statistical Analysis

Data analysis was performed using the Statistical Package for the Social Sciences (SPSS) version 25.0. Categorical data were expressed as percentages and frequencies, while continuous variables were presented as mean values±standard deviations. The normal distribution of the data was assessed using the Kolmogorov-Smirnov test. The Chi-Square test was applied to examine associations between categorical variables, and one-way analysis of variance (ANOVA) was used for continuous variables. Multivariate logistic regression analysis was employed to identify characteristics that independently predicted a change in diagnosis to schizophrenia, schizotypal, delusional, and other non-affective psychotic disorders. Binary logistic regression analyses were performed to determine odds ratios (OR) along with 95% confidence intervals (CI). Multicollinearity among the predictor variables in the multivariate model was assessed using a correlation matrix, while the overall predictive accuracy of the model was evaluated using a classification table (24, 25). The Nagelkerke $R^2$ was utilized to quantify the proportion of variance explained by the model (26). Statistical significance was set at $p<0.05$.

**Table 1: Sociodemographic and clinical characteristics of patients with initial diagnosis of acute and transient psychotic disorder (ATPD)**

| | |
|---|---|
| Sociodemographic characteristics | |
| Age (years) Mean±SD | 29.90±10.33 |
| Follow-up (months) Mean±SD | 63.94±32.98 (range: 36–124) |
| Gender, n (%) | |
| Female | 49 (46.2) |
| Male | 57 (53.8) |
| Marital status, n (%) | |
| Unmarried | 66 (62.3) |
| Married | 40 (37.7) |
| Education, n (%) | |
| Primary education | 60 (53.6) |
| Secondary education and higher | 46 (43.4) |
| Employment, n (%) | |
| Employed | 69 (65.1) |
| Unemployed | 37 (34.9) |
| Clinical characteristics | |
| Family history, n (%) | 34 (32.1) |
| Psychiatric history, n (%) | 68 (63.8) |
| Hospitalization during admission, n (%) | 56 (52.8) |
| Substance use, n (%) | 23 (21.7) |
| Stressful life event, n (%) | 64 (60.4) |
| Delusion, n (%) | 97 (91.5) |
| Hallucinations, n (%) | 50 (47.2) |
| disorganized speech or behavior, n (%) | 54 (50.9) |
| Sleep disturbance, n (%) | 87 (82.1) |

SD: standard deviation; ATPD: Acute and transient psychotic disorder.

## RESULTS

### Sample Characteristics

The final study sample included 106 patients (57 males, 49 females) with a mean age of 29.90±10.33 years. The predominant sociodemographic characteristics of the sample were as follows: 62.3% (n=66) were

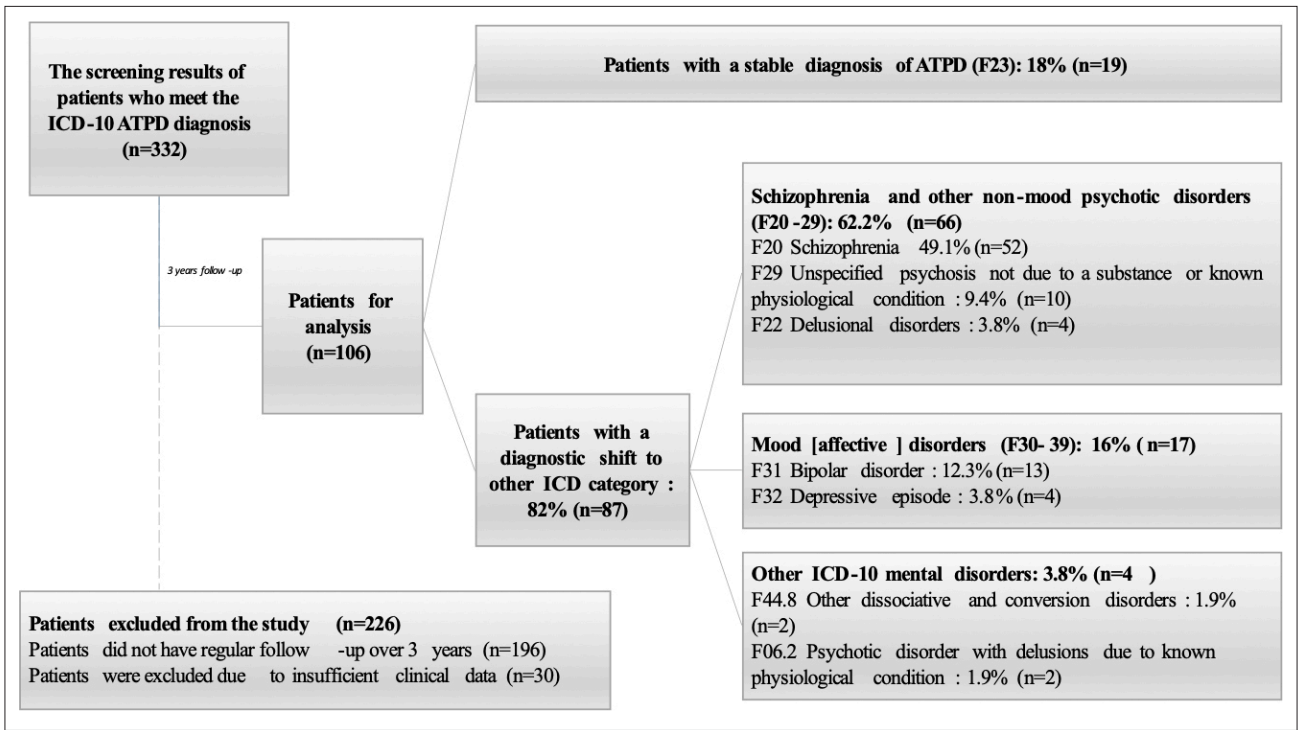


**Figure 1.** Diagnostic stability of patients with first-episode acute and transient psychotic disorder (ATPD) after three years of follow-up.

unmarried, 65.1% (n=69) were employed, and 53.6% (n=60) had a primary education level. Additional findings included: 32.1% (n=34) had a first-degree family history of psychiatric disorders, 63.8% (n=68) had a psychiatric history, 21.7% (n=23) had a history of substance use, 60.4% (n=64) experienced at least one stressful life event prior to the diagnosis of ATPD, and 30% (n=21) had a history of hospitalization immediately following the ATPD diagnosis. At the time of ATPD diagnosis, 91.5% (n=97) exhibited delusions, 47.2% (n=50) experienced hallucinations, 50.9% (n=54) demonstrated disorganized speech or behavior, and 82.1% (n=87) suffered from sleep disturbances (Table 1).

### Diagnostic Stability of ATPD and Pattern of Diagnostic Shift Over Three Years of Follow-Up

Diagnostic stability was observed in 17.8% of the patients. At the three-year follow-up, the distribution of diagnoses was as follows: 49.1% of patients were diagnosed with schizophrenia (code F20 and its subcodes), 9.4% with unspecified psychosis (F29), 3.8% with persistent delusional disorder (F22 and its subcodes), 12.3% with bipolar disorder (F31 and its subcodes), 3.8% with major depressive disorder (F32 and its subcodes), 1.9% with dissociative disorder (F44.8), and 1.9% with organic delusional disorder (F06.2) (Fig. 1).

### Comparison of Diagnostic Groups in Terms of Sociodemographic and Clinical Characteristics

For comparative analysis of sociodemographic and clinical characteristics, three main diagnostic groups were identified: (i) ATPD (F23.9; n=17), (ii) schizophrenia spectrum and other psychotic disorders (F20–29; n=66), and (iii) affective disorders (F30–39; n=19) (Fig. 1, Table 2). Significant differences were found between these groups in terms of education level ($\chi^2$=9.776, p=0.008) and hospitalization history ($\chi^2$=8.083, p=0.018). No significant differences were observed for other parameters (Table 2).

### Predictors of Diagnostic Shift to Schizophrenia and Other Non-Affective Psychotic Disorders

Based on the literature and study findings, age, primary education level, and hospitalization history were included as independent variables in the model (Table 3). Multivariate logistic regression analysis revealed that age (OR=0.951, 95% CI 0.90–0.96; p=0.032) and primary education level (OR=0.219, 95% CI 0.08–0.54; p=0.001) were independently and significantly associated with a diagnostic shift to schizophrenia spectrum and other psychotic disorders. Hospitalization history did not show significant independent associations. The correlation matrix indicated no collinearity issues among the covariates. The multivariate model was statistically

**Table 2: Comparison of diagnostic groups in terms of sociodemographic and clinical characteristics**

| Characteristic | ATPD (n=19) | Schizophrenia and other non-affective psychotic disorders (n=66) | Affective disorders (n=17) | p |
|---|---|---|---|---|
| Age (years), Mean±SD | 30.89±9.89 | 28.47±8.91 | 28.62±9.62 | 0.176[a] |
| Follow-up (months), Mean±SD | 60.37±36.30 | 68.44±37.81 | 59.00±25.69 | 0.542[a] |
| Gender, n (%) | | | | 0.406[b] |
| Female | 9 (47.4) | 27 (40.9) | 10 (58.8) | |
| Male | 10 (52.6) | 39 (59.1) | 7 (41.2) | |
| Education, n (%) | | | | 0.008[b]* |
| Primary education | 7 (36.8) | 45 (68.2) | 6 (35.3) | |
| Secondary and higher | 12 (63.2) | 21 (31.8) | 11 (64.7) | |
| Marital status, n (%) | | | | 0.388[b] |
| Unmarried | 12 (63.2) | 43 (65.2) | 8 (47.1) | |
| Married | 7 (36.8) | 23 (34.8) | 9 (52.9) | |
| Employment, n (%) | | | | 0.987[b] |
| Employed | 12 (63.2) | 43 (65.2) | 11 (64.7) | |
| Unemployed | 7 (36.8) | 23 (34.8) | 6 (35.3) | |
| Family history, n (%) | 8 (42.1) | 22 (33.3) | 4 (23.8) | 0.498[b] |
| Psychiatric history | 12 (63.2) | 45 (68.2) | 7 (41.2) | 0.121[b] |
| Hospitalization during admission, n (%) | 5 (26.9) | 38 (57.6) | 12 (70.6) | 0.018[b]* |
| Substance use history, n (%) | 4 (21.1) | 15 (22.7) | 2 (11.8) | 0.608[b] |
| Stressful life event, n (%) | 9 (47.4) | 41 (62.1) | 12 (70.6) | 0.338[b] |
| Delusion, n (%) | 17 (89.5) | 62 (93.9) | 15 (88.2) | 0.657[b] |
| Hallucinations, n (%) | 7 (36.8) | 30 (45.5) | 11 (64.7) | 0.224[b] |
| Disorganized speech or behavior, n (%) | 12 (63.2) | 30 (45.5) | 10 (58.8) | 0.308[b] |
| Sleep disturbance, n (%) | 18 (94.73) | 52 (78.8) | 12 (70.6) | 0.163[b] |

a: One-way analysis of variance (ANOVA) test; b: Chi-square test; *: p<0.05; ATPD: Acute and transient psychotic disorder.

significant ($\chi^2$=8.840 [8], p=0.001) and accounted for 18.4% of the variance (Nagelkerke $R^2$=0.184).

## DISCUSSION

The aim of this study was to investigate diagnostic stability and the factors associated with diagnostic changes in patients with ATPD over a follow-up period of three years. Our main findings indicate that the stability rate of ATPD diagnosis in Turkiye is low, with most diagnostic changes shifting towards schizophrenia and related psychotic disorders. Additionally, lower educational status was identified as a predictor of diagnostic change favoring schizophrenia and related disorders.

In this study, a total of 106 patients were reviewed retrospectively, and the diagnostic stability rate was found to be 17.8%. Studies have reported varying rates of diagnostic stability for ATPD in different countries. For instance, a prospective study conducted in Spain reported a diagnostic stability rate of 55.9%, with multiple regression analyses showing a significant association between diagnostic stability and the presence of polymorphic symptomatology, as well as the absence of schizophrenic features at disease onset (27). However, our study did not find a relationship between symptom characteristics and diagnostic stability. In another study from Northern Europe, the diagnostic stability rate was found to be 58% at a six-year follow-up (16). These differences may be related to variations in follow-up periods, sample sizes, or inclusion criteria across studies. In our study, a significant number of patients were excluded due to lack of regular follow-up. We can speculate that patients who do not attend regular follow-ups may have experienced no recurrence of symptoms, suggesting that their final diagnosis remained ATPD. If we consider that the excluded

**Table 3: Predictors of diagnostic shift to schizophrenia and other non-affective psychotic disorders: Results of multivariate logistic regression analysis**

| | B | S.E. | Wald | Sig. | OR | 95% CI |
|---|---|---|---|---|---|---|
| Step 1 | | | | | | |
| Age (years) | -0.053 | 0.024 | 4.987 | **0.026** | 0.949 | 0.906–0.994 |
| Primary education | 1.536 | 0.468 | 10.771 | **0.001** | 0.215 | 0.086–0.539 |
| Hospitalization | -0.52 | 0.453 | 1.318 | 0.251 | 0.594 | 0.244–1.445 |
| Constant | 3.189 | 0.913 | 12.192 | <**0.001** | 24.264 | |
| Step 2 | | | | | | |
| Age (years) | -0.05 | 0.023 | 4.614 | **0.032** | 0.951 | 0.909–0.996 |
| Primary education | -1.517 | 0.463 | 10.723 | **0.001** | 0.219 | 0.088–0.544 |
| Constant | 2.843 | 0.839 | 11.476 | **0.001** | 17.164 | |
| Model summary | | | | | | |
| Nagelkerke $R^2$ | | | 0.184 | | | |
| $\chi^2$ [df] (p) | | | 8.84 [8] (p=0.001) | | | |

SE: Standard error; OR: Odd ratio; CI: Confidence interval.

patients belonged to the non-recurrent ATPD group, the stability rate would likely be significantly higher. Indeed, Adamsoo et al. (10) found a similarly low diagnostic stability rate of 34% using a comparable method. In a 2021 meta-analysis, Provenzani et al. (12) reported that the risk of diagnostic change and symptom recurrence was particularly high during the first three years, suggesting that the follow-up period should be a minimum of three years. Consistent with these recommendations, our study included patients with follow-up records spanning at least three years. This criterion may also contribute to the observed low diagnostic stability. Furthermore, in Turkiye, the limited number of psychiatrists per capita, high patient load, and short consultation times often prevent detailed diagnostic assessments for patients presenting with psychotic symptoms. The need for rapid diagnosis and treatment may lead to the misdiagnosis of ATPD. During subsequent follow-ups, detailed history-taking may reveal diagnostic changes, contributing to the low diagnostic stability observed in our study. Additionally, even in correctly diagnosed patients, variations in the duration of symptoms, the emergence of new symptoms over time, and treatment responses may necessitate re-evaluation of the diagnosis, further contributing to low diagnostic stability.

In our study, the mean age of patients initially diagnosed with ATPD was determined to be 29.9 years (late third decade). This corresponds to the common onset age for most psychiatric disorders, including schizophrenia and other psychotic disorders. The prevalent onset age for ATPD has been reported to be between the second and third decades of life in both developed and developing countries (18, 28). Although earlier studies indicated that ATPD was more frequently observed in females (4, 13, 21), more recent studies and meta-analyses have shown no significant gender difference (6, 29, 30). Consistent with recent literature, we also found the male-to-female ratio to be nearly equal (male/female: 1.16). The frequency of stressful life events prior to disease onset was identified as 60.4% in our study. However, similar to findings in previous studies, no correlation was found between the presence of stressful life events and future diagnostic changes (13, 16, 27).

In our study, the most common symptoms in patients presenting with a diagnosis of ATPD were delusions (91.5%), sleep disturbances (82.1%), disorganized speech and behavior (50.9%), and hallucinations (47.2%). Among patients with a diagnostic change, schizophrenia and other psychotic disorders were identified in 62.3%, and affective disorders in 16.1%. Numerous studies have reported that the most frequent diagnostic change in ATPD patients favors schizophrenia and other psychotic disorders (11, 28). The similarity of these results across many studies suggests that ATPD may have greater similarities to schizophrenia and other psychotic disorders, despite being genetically and phenomenologically defined as a separate category. Conversely, a 20-year retrospective follow-up study reported that 55.4% of patients developed affective disorders (14). In another study, the majority of patients who experienced a diagnostic change from ATPD were found to have bipolar affective disorder (22). Other studies have also reported higher rates

of conversion to affective disorders during follow-up (28). The discrepancies in study results may be attributed to differences in methodological approaches, follow-up duration, diagnostic systems used, geographical regions, and cultural variations. In Turkiye, a study by Ozturk et al. (17) similarly reported high rates of diagnostic change, most commonly to schizophrenia and related psychotic disorders, which aligns with our findings. The similarity between these studies may be related to the pervasive issue of stigma against mental illnesses, both globally and in Turkiye (29). Clinicians may prefer an initial diagnosis of ATPD at first admission to shield patients from stigma and to encourage their adherence to treatment. This may account for both the low diagnostic stability and the high rate of conversion to schizophrenia and related psychotic disorders during follow-up. It may be beneficial for future studies investigating ATPD diagnostic stability and related factors to also explore the roles of stigma and clinician attitudes.

Numerous factors that might predict diagnostic changes in patients initially diagnosed with ATPD have been investigated, but no definitive conclusions have been reached (11, 12). Although not consistently replicated, male gender, younger age at onset, poor premorbid psychosocial adjustment, non-abrupt onset of psychotic symptoms, the presence of hallucinations, and Schneiderian first-rank symptoms appear to be predictive factors for a poor prognosis and transition to schizophrenia and related psychotic disorders (23, 27). In our study, we did not identify any association between symptom clusters and diagnostic changes (Table 2). We found that patients who transitioned to a diagnosis of schizophrenia and psychotic disorders had lower educational levels compared to those who maintained their diagnosis of ATPD or transitioned to affective disorders ($p<0.05$) (Table 2). Lower educational levels may contribute to difficulties for psychotic patients in expressing themselves and their complaints, potentially leading to an early diagnosis of ATPD. Although it did not reach statistical significance, the longer follow-up duration for patients diagnosed with schizophrenia and other psychotic disorders supports our observation. This tendency might also be related to physicians being more inclined to diagnose schizophrenia in patients with lower educational levels, regardless of their symptom profiles. Further studies examining the relationship between educational levels and physicians' tendencies to diagnose psychotic disorders could provide valuable insights.

In the multiple analysis of predictors for the transition to schizophrenia and related psychotic disorders, younger age at psychosis onset and lower educational level at presentation were identified as independent predictive factors (Table 3). Similar to our findings, some studies have reported that earlier onset age is associated with an increased risk of transition to schizophrenia and related disorders (8, 11). Queirazza (6) and colleagues reported that, in addition to onset before the age of 30, male gender and hospitalizations longer than two weeks at presentation were associated with the transition to a diagnosis of schizophrenia. The diagnostic transition towards schizophrenia and other psychotic disorders in patients with an early onset age and lower educational levels may be associated with the neurodevelopmental model of the disease. On the other hand, a prospective follow-up study published in 2024 found that low premorbid functioning and the presence of schizophreniform symptoms at the onset of illness were associated with the transition to non-affective psychosis (18). Methodological differences between studies, as well as genetic, phenomenological factors, and individual differences associated with the diagnosis of schizophrenia, may limit the ability to achieve more definitive results.

Studies investigating the prevalence and diagnostic stability of psychiatric disorders in Turkiye are limited. To our knowledge, this study is the first to evaluate the long-term diagnostic stability of ATPD and associated factors in Turkiye. The findings of this study are noteworthy, particularly the identification of educational level as an independent predictive factor for the transition to schizophrenia and other psychotic disorders.

However, the study has some limitations. The retrospective design is the primary limitation, as symptoms and findings could not be supported by clinical scales, thereby restricting the quality and quantity of the data. Additionally, the small number of patients who attended regular follow-ups is another significant limitation. The relatively small sample size further reduced the statistical power of the study. Moreover, the culture-dependent aspect of the ATPD diagnosis limits the generalizability of the findings. Despite numerous studies, the lack of consensus on diagnostic stability and related factors in ATPD patients necessitates the evaluation of non-patient factors in diagnostic changes. Consequently, there is a need for large-sample, prospective studies that also assess the roles of clinician attitudes and stigma in the diagnostic stability of ATPD.

## CONCLUSION

This study highlights the low diagnostic stability of ATPD in Turkiye, with a significant proportion of initial ATPD diagnoses transitioning to schizophrenia and related psychotic disorders during a three-year follow-up. The findings underscore that younger age at onset and lower educational level are significant predictors of diagnostic change, suggesting the influence of developmental and sociodemographic factors on long-term outcomes. These results emphasize the importance of follow-up and comprehensive diagnostic evaluations in managing ATPD. Future large-scale, prospective studies are necessary to further explore the factors influencing diagnostic stability, including the roles of clinician attitudes and stigma in psychiatric diagnosis. This study also advocates for a more nuanced approach to diagnosing and treating ATPD to improve long-term prognosis.

| Contribution Categories | | Author Initials |
|---|---|---|
| Category 1 | Concept/Design | B.K., M.H.A. |
| | Data acquisition | I.Y., S.O. |
| | Data analysis/Interpretation | M.H.A., B.K. |
| Category 2 | Drafting manuscript | B.K., I.Y., S.O. |
| | Critical revision of manuscript | B.K., M.H.A. |
| Category 3 | Final approval and accountability | B.K., M.H.A., I.Y., S.O. |
| Other | Supervision | B.K., M.H.A. |

**Ethical Approval:** The Gazi University Faculty of Medicine Ethics Committee granted approval for this study (date: 11.07.2023, number: 2023-889).

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