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DSM-5 and the 'Psychosis Risk Syndrome': The DSM-5 proposal is better than DSM-IV

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Abstract

The American Psychiatric Association is considering the inclusion of the psychosis risk syndrome as a new diagnosis for DSM-5. The main evidence supporting inclusion is: (1) the patients meet criteria for having a current illness, (2) the patients are at high risk for becoming more severely ill, (3) no DSM-IV diagnosis accurately captures their current symptoms or future risk, (4) the diagnosis is reliable and valid, at least in the research setting, and (5) codification in DSM-5 will promote treatment and prevention research of sufficient quantity and quality to permit the development of treatment guidelines. Field trials are needed to determine whether the proposed diagnostic criteria can be used with reliability in actual clinical practice.

Keywords

risk syndrome; schizophrenia; psychosis; early detection; prevention; DSM-5

The term "risk syndrome for psychosis" has recently been used to describe patients with subsyndromal or attenuated positive symptoms at high risk for developing frank psychosis (Woods et al., 2009). Although the name is new, the concept rests on a substantial research database from multiple centers across the world over the past 15 years. Other names have also been used in the literature, including "at-risk mental state", "ultra-high risk", and "putatively prodromal".

Earlier this year, the American Psychiatric Association DSM-5 Task Force posted on its website draft criteria for the psychosis risk syndrome as a proposed new diagnosis (Carpenter, 2009) and invited comment. Revised draft criteria were then posted based on the comments received.

The psychosis risk syndrome is reliable and valid in the research setting

Research has clearly established the reliability and validity of the risk syndrome diagnosis in the research setting (Woods, 2010). Two structured diagnostic interviews have been developed, and diagnostic interrater reliability for one of these has been published for 11 separate sites. Three additional studies demonstrate excellent interrater reliability for severity of the diagnostic positive symptoms. Two studies show predictive validity for psychosis outcomes, compared to patients referred specifically for risk syndrome structured interview who did not meet criteria. Patients meeting criteria were at 10- to 12-fold higher risk than patients who did not meet criteria. The largest study found that 40% of patients transitioned to psychosis over a 2.5-year period (Woods et al., 2009).

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The DSM-5 Task Force is not assuming that the strong reliability record in the research setting can translate directly to the clinical setting. Before the risk syndrome can be further considered for DSM-5, diagnostic reliability must be demonstrated in field trials employing usual care clinicians.

The patients are currently ill, and also at risk for getting worse

Risk syndrome patients are all symptomatic, and many seek treatment. As a group, they are functionally impaired (Global Assessment of Functioning (GAF) scores are usually in the 40s and 50s when 70 is the cut-off for disorder). Cognitive impairment has been demonstrated relative to controls in 20/23 studies. These features of risk syndrome patients should by themselves qualify them for a DSM diagnosis. However, no DSM-IV diagnosis accurately captures their symptoms.

The “risk” from the syndrome is relatively specific for psychosis

Studies suggest that DSM-IV diagnoses at conversion from the risk syndrome include 15–25% affective psychoses (Woods et al., 2009). The remainder are schizophrenic psychoses and other nonaffective psychoses such as psychosis NOS. Although the majority of cases do not convert and many of the remainder qualify for affective diagnoses at follow-up, it is not true that the psychosis risk syndrome most frequently *develops into* nonpsychotic affective disorder. The very large majority of these cases meet criteria for depression comorbidly at baseline, and their mood disorder persists through follow-up. Newly emergent or incident nonpsychotic affective disorder is a rare outcome, especially compared with the frequency of incident psychoses. Thus the psychosis risk syndrome is quite specific in predicting psychosis among the incident outcomes. Moreover, the large majority of young people with persistent depression likely do not have attenuated positive symptoms that qualify for a DSM-5 risk syndrome diagnosis.

Risk is lower when we screen – so maybe we shouldn’t

It is often repeated that recent studies suggest lower conversion rates than earlier studies. Such comments should immediately raise the question of what may be causing the supposed temporal effect. The conversion rate should be affected by two main factors: the criteria themselves and the population to which the criteria are applied.

When we screen for people who meet criteria rather than respond to referrals from persons, families, and practitioners who have a specific concern about psychosis, conversion rates drop. In a 2008 paper, Yung and colleagues reported on the two-year outcomes of conducting their risk syndrome structured interview on all comers to their general youth mental health triage system (Yung et al., 2008). Only 16% became psychotic within two years, compared to roughly 40% when the same criteria were previously applied to a specific referral population.

The lesson we should learn from this experience is not that the proposed DSM-5 criteria are flawed. Rather, we should apply risk syndrome criteria only to individuals for whom there is a specific concern about psychosis as opposed to those with any and all psychiatric complaints. Clinicians in actual practice will not consider the diagnosis for every patient who comes in the door, but will focus on those patients whose chief complaint and related symptoms suggest the diagnosis for consideration.

The DSM-5 criteria should identify a higher-risk group than the research criteria

Criterion D for the proposed DSM-5 diagnosis requires that patients be distressed by their symptoms, functionally impaired, and seeking help. None of these requirements are present in the research criterion sets in current use, and so the proposed DSM-5 criteria are narrower than those used in research. At least six large studies, including three with multivariate analyses (Cannon et al., 2008; Ruhrmann et al., 2010; Yung, Phillips, Yuen, & McGorry, 2004), identified impaired functioning as an independent predictor of conversion that was additive to the research criteria. Specifically, lower-functioning patients who met research criteria converted at higher rates than higher-functioning patients who met research criteria. Thus the narrower DSM-5 criteria are designed to yield higher conversion rates based on strong existing evidence.

The DSM-5 proposal is better than DSM-IV for these patients

Recent data from our site indicate that clinicians currently give risk syndrome patients a variety of DSM-IV diagnoses, the most frequent of which is 298.9 psychotic disorder NOS (Woods, 2010). Others include attention deficit disorder and oppositional defiant disorder. An empathic discussion with a patient about what it means to be at risk cannot be more stigmatizing than a diagnosis that falsely states full psychosis is already present or states that the patient is oppositional. It is certainly arguable that overtreatment with antipsychotics could even be reduced by a risk syndrome diagnosis, relative to the psychosis NOS diagnosis.

Right now, much of the controversy about the risk syndrome diagnosis is attributable to a lack of data. In 15 years we have published only 4 randomized studies, and none of these can boast as many as 100 patients. No wonder there is no consensus on a standard of care, and thus great practice variation. If a risk syndrome diagnosis is codified in DSM-5, a likely result will be more research and larger trials that will provide definitive answers. For example, if antipsychotics do more harm than good, large trials will make a clear demonstration for practice. Equally important, more rapid development of new treatments that may be safe and specific for this phase of illness (Amminger et al., 2010) would undoubtedly be facilitated by placement in DSM-5.

Should we have other risk syndromes?

McGorry's vision of clinical staging in psychiatry (Johannessen & McGorry, 2010), with an early stage being a plenipotentiary risk syndrome, has much to commend it. Unfortunately, as yet we have no hard data to support it. Before adoption could be urged, for each stage we would need reliability data on specific criteria and predictive validity data on specific outcomes, much as we now have for the psychosis risk syndrome. Other, more specific risk syndromes, such as a depression risk syndrome, would also be welcome if we had the data to support them. Beyond the psychosis risk syndrome, the only other risk syndrome that seems ready for consideration for DSM-5 is the dementia risk syndrome generally known as mild cognitive impairment (MCI) or, in the DSM-5 proposal, minor neurocognitive disorder. The rate to conversion from MCI to dementia is generally held to be around 12% per year (Petersen et al., 1999), depending on the method of sample ascertainment. This rate is comparable to, or a little lower than, the rate for the psychosis risk syndrome, also depending on the method of sample ascertainment.

A rose by any other name …

Consideration of the psychosis risk syndrome in DSM-5 has been controversial (Kaymaz & van Os, 2010; Kingdon, Hansen, & Turkington, 2010), and one of the more controversial aspects is the name. We coined the term “risk syndrome” for psychosis (Woods et al., 2009) because the patients have a syndrome (symptoms and impairment) that connotes risk of getting worse (conversion to psychosis). A syndrome that connotes risk, or risk syndrome. The term is distinguished from a risk factor, such as hyperlipidemia, that connotes risk but may be associated with no current symptoms or impairment of functioning.

A name that focuses on the current symptoms and impairment rather than the risk may be more palatable. Attenuated psychotic symptoms syndrome, or APS syndrome, has been suggested. Such a suggestion is in keeping with the most common name for the mild cognitive impairment syndrome, where the MCI name does not mention the risk for dementia.

Whether the name contains the word “risk” or not, the risk itself is quite real, and our patients and their families already suspect it and already fear it. Whatever we call the syndrome, we must be prepared as clinicians to discuss risk, empathically and straightforwardly, or we will perpetuate with our silence the very fear and stigma we seek to avoid.

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