Editorial

Attenuated Psychosis Syndrome

Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM - 5) included attenuated psychosis syndrome (APS) in Section III under "conditions for further study". The DSM - 5 task force determined that there was insufficient evidence to warrant inclusion of APS as official mental disorder diagnosis in Section II. "The proposed criteria (APS) are not intended for clinical use; only the criteria sets and disorders in Section II of DSM - 5 are officially recognized and can be used for clinical purposed."[1]

In a study by Tsuang *et al*.[2] explains the position as "despite advances in the treatment of schizophrenia over the past half-century, the illness is frequently associated with a poor outcome. This is principally related to the late identification and intervention in the course of the illness … can be difficult to reverse. The emphasis has therefore shifted to defining psychosis-risk syndromes and evaluating treatments that can prevent transition to psychosis in these ultra-high risk groups. To consider the appropriateness of adding psychosis risk syndrome to our diagnostic nomenclature, the psychotic disorders work group extensively reviewed all available data, consulted a range of experts and carefully the variety of expert and public comments on the topic. It was clear that reliable methods were available to define a syndrome characterized by sub-threshold psychotic symptoms (in severity or duration) and which was associated with a very significant increase in the risk of development of a full-fledged psychotic disorder … within the next year".

Shrivastava *et al*.[3] reviewed the current status of research…. arguments for, against and alternatives for inclusion (APS) as a diagnosis and made an attempt to provide a critical synthesis of opinions on this…

APS denotes a kind of temporary culmination of a quarter century of research on early psychosis, the prime goal being to reduce/eliminate duration of untreated psychosis (DUP). DUP is a well-documented and accepted prognostic indicator in Schizophrenia – longer the DUP, worse the outcome - keeping all other factors controlled. For long researchers, especially McGory and his group have been working on identifying and diagnosing psychosis at its earliest presentation, prodromal state and even prior to prodrome "At risk state", with the hope of bettering the outcome in Schizophrenia. Identification of persons with clinically high risk/ultra high risk/at risk mental state (ARMS) stays as the essential component of primary prevention (akin to diabetes mellitus!!!) in schizophrenia. There has been reasonable progress in this area with identification of patients termed "ARMS", the risk predominantly meaning progression into schizophrenia.

Specific diagnostic symptoms have been enumerated and for better objectivity several scales have been used – comprehensive assessment of at-risk mental states; structured interview for prodromal syndromes/scale of prodromal symptoms, prodromal questionnaire (PQ) 16[4,5] which can be administered with reasonable inter rater reliability to identify patients with ARMS. Of course, there always was a note of caution about high risk of false positives, the stigma and inappropriate interventions!

Attempts to identify specific markers for APS in neuroimaging studies have not been successful and there is an overall lack of consistency as to which of these alterations predict the development of psychosis.[6] Literature review regarding intervention benefits has been summed up - benefits for any specific intervention is not conclusive… it might be possible to delay or prevent transition to psychosis. Although clinical trial findings have been inconsistent, psychosocial approaches …may reduce the risk of transition to psychosis![7,8]

As there was much work going on in some specific centers about the early psychosis, significant changes have occurred in the field of schizophrenia in the last 2-3 decades on a parallel stream.– We have come a long way in the diagnostic process of schizophrenia:

From - absence of rapport, wall between patient and the doctor, bizarreness in behavior, pathognomonic significance of the first rank symptoms, pseudo neurotic schizophrenia, simple schizophrenia…..

Access this article online	
Website: www.ijpm.info	Quick Response Code
DOI: 10.4103/0253-7176.127239	

To - focus on delusions and hallucinations (qualitatively better definable symptoms), mandatory 6 months duration, less importance to negative symptoms…..

In my personal opinion, doing away with the subtypes is a major achievement of DSM - 5 and a significant milestone in the conceptualization of schizophrenia, in a definitive positive direction.

The proposed diagnostic criteria for APS in DSM - 5:

a. At least one of the following of symptoms is present in attenuated form, with relatively intact reality testing and is of sufficient severity or frequency to warrant clinical attention:
   - Delusions
   - Hallucinations
   - Disorganized speech.
b. Symptom(s) must have been present at least once per week in the last 1 month
c. Symptom(s) must have begun or worsened in the past year
d. Symptom(s) is sufficiently distressing and disabling to the individual to warrant clinical attention
   Symptom(s) is not better explained by another mental disorder, including: Depressive or bipolar disorder with psychotic features and is not attributable to physiological effects of a substance or another medical condition
e. Criteria for any psychotic disorder have never been met.

Conceptualization and categorization of APS in DSM - 5 was not a smooth affair as was well argued out in "whither the APS".[9] The proposed diagnostic criteria, concept and positioning of APS in DSM - 5 created its own share of whys and hows:

1. Attenuated delusion

Descriptive psychopathology IS the fundamental professional skill….the only diagnostic skill unique to the Psychiatrist…

Delusion is defined as: False belief, unshakeable belief, held with extraordinary conviction, with subjective certainty….

The decision to call a belief delusional is not made by the person holding the belief, but by an external observer.

The description in DSM - 5 of attenuated delusion – "skepticism …can be elicited with persistent questioning and confrontation" – goes in contrast to the basic definition of Delusion defined in any text book of psychiatry.

Skepticism about the "trueness of the belief" makes it no longer a delusion! Same is the case with description of attenuated hallucination – "skepticism about the reality can still be induced…"

2. You find APS described in DSM - 5 in
   - The Section III (page 783) and also in
   - The Section II (page 122) - APS[10]

Among the examples for presentation of "Other specified schizophrenia spectrum and other psychotic disorder" (298.8) for reasons best known to authors!!!

3. "Psychosis risk syndrome" to "APS":

Simon[10] enquired the reason for changing the name wondering whether it serves the purpose of reducing the stigma, which obviously is not so, as stigma is more for the word "psychosis"! in their reply.[11]

William Carpenter, Darrel Regier, Rajiv Tandon elaborated that the metamorphosis of "psychosis risk syndrome" to "APS" in DSM - 5 is because "this change instead recognized that a disorder meriting clinical attention was already being manifest and this was explicit in the proposed criteria … and APS is no more as… hypercholesterolemia… but as ….angina."

APS is thus no more at risk syndrome but a clinical entity demanding attention-makes sense to understand APS as early/mild psychosis. Then why is it not in Section II?

"Concern has been that this diagnosis might result in inappropriate treatments," asserts Darrel Regier, Vice-chairman of the DSM - 5 task force.

"Early-intervention ideas are powerful, but very neglected in psychiatry," "I would hate to see the last 25 years of work on high-risk syndrome thrown out of the window" says Patrick McGorry who worries that the topic might fall by the wayside before the next revision.

"Psychotic risk syndrome is valid. Intervening at a pre psychotic stage could ameliorate and even thwart this serious mental illness in a large number of people… individuals who fit the putative criteria for the psychosis risk syndrome – now officially dubbed APS – are tens to hundreds of times more likely to develop schizophrenia and psychosis than the average person." says William Carpenter, chairman of the task force on schizophrenia spectrum disorders for DSM - 5.

The "whys" and "hows" remain unanswered satisfactorily (answered though) and the debate thus goes on….

Loud thinking for future research on APS!

1. Include positive family history of psychosis as a criterion
2. Revisit the concept of attenuated delusions, hallucinations…
3. Long-term (10 years…) follow-up studies - ? course
4. Antipsychotic treatment – long-term and short term trials
5. Percentage of conversion into schizophrenia over a 10 year period
6. Percentage of conversion into bipolar disorder.

DSM - 6 – Staging of Schizophrenia!!!!!!!!!

Primary Prevention in Psychiatry!!!!!!!!!

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How to cite this article: Reddy MS. Attenuated psychosis syndrome. Indian J Psychol Med 2014;36:1-3.