

Western University

From the SelectedWorks of Amresh Srivastava

June 2010

Should “Risk Syndrome for Psychosis” Be Included as a Diagnosis in DSM-V?

Contact
Author

Start Your Own
SelectedWorks

Notify Me
of New Work



Available at: <http://works.bepress.com/amreshsrivastava/82>

Should “risk syndrome for psychosis” be included as a diagnosis in DSM-V?

Research on people at ultra high risk to develop schizophrenia has progressed significantly in recent years (1-5). This has led to the proposal, which has appeared in the agenda of the work group on schizophrenia of the American Psychiatric Association (6), to include “risk syndrome for psychosis” as a diagnosis in DSM-V.

Different positions have been expressed in this respect. Most experts feel that “risk syndrome for psychosis” is not a diagnostic entity (6). Including it as a diagnosis may be detrimental, due to the possibility of inappropriate labeling, prescribing of antipsychotics and stigma leading to discrimination. Furthermore, the syndrome is ill-defined, with no neurobiological basis, lack of specific treatments, and need for further evaluation. Potential harm outweighs potential benefits at present, because of poor validation, low and declining conversion rate, and high rate of false positives.

However, it is also true that everyone who develops psychosis or schizophrenia has been “at-risk”, and prevention of schizophrenia is possible only if we are able to effectively detect the risk. Therefore, it may not be prudent to dismiss the proposal altogether. The strongest argument for the inclusion of the new diagnosis is based upon the “staging model” illustrated by P. McGorry (7,8). According to the proponents, the evidence is now sufficient, public health implications are clear, and the new diagnosis would offer a great opportunity to pursue schizophrenia research from a prodromal perspective (9,10). Though it is recognized that only some people actually progress to a psychotic state, it is maintained that some indication about who will develop psychosis is now emerging.

According to existing diagnostic systems, patients are classified as either having a psychotic condition or not having it. In routine clinical practice, the subsyndromal or sub-threshold clients are turned away because diagnostic criteria are not fulfilled. Help seeking individuals at times may remain under observation without active intervention, and those who fail to recognize their symptoms may only be referred when it is too late. There is a need to address the vulnerable people on an ongoing basis to either delay or avert psychosis, exactly like we do for evolving myocardial ischemia or evolving stroke. We certainly need more effective and specific instruments, measurements and definitions to facilitate this process.

Psychiatric diagnosis is the universal language of mental health, which provides effective communication amongst the clinicians. However, it has outgrown its purpose, and has acquired position of a document providing scientific

evidence for a number of non-clinical arenas like courts, insurance companies, social service disability, research funding and research ethics boards. We need to reconcile with this change.

The risk syndrome for psychosis may or may not appear in DSM. Several other options may be considered instead of calling it a “diagnosis”, e.g., a separate category of subsyndromal psychosis or a category of risk syndromes across the diagnoses, or coding it on a dimension of severity. While more discussion regarding research evidence, theoretical aspects and ethical boundaries is certainly required, I would like to welcome this debate and hope to see it reaching a logical conclusion.

Amresh Shrivastava

University of Western Ontario, and Lawson Health Research Institute, London, Ontario, Canada

References

1. Addington J, Cadenhead KS, Cannon TD et al. North American Prodrome Longitudinal Study: a collaborative multisite approach to prodromal schizophrenia research. *Schizophr Bull* 2007;33:665-72.
2. Yung AR, Nelson B, Stanford C et al. Validation of “prodromal” criteria to detect individuals at ultra high risk of psychosis: 2 year follow-up. *Schizophr Res* 2008;105:10-7.
3. McGorry PD, Killackey E, Yung A. Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry* 2008;7: 148-56.
4. Malla A. The promises and challenges of early intervention in psychotic disorders. *World Psychiatry* 2008;7:157-8.
5. Klosterkötter J. The clinical staging and the endophenotype approach as an integrative future perspective for psychiatry. *World Psychiatry* 2008;7:159-60.
6. Schizophrenia Research Forum. Live discussion: is the risk syndrome for psychosis risky business? www.schizophreniaforum.org.
7. McGorry PD, Hickie IB, Yung AR et al. Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier, safer and more effective interventions. *Aust N Zeal J Psychiatry* 2006;40: 616-22.
8. McGorry PD, Nelson B, Amminger GP, et al. Intervention in individuals at ultra high risk for psychosis: a review and future directions. *J Clin Psychiatry* (in press).
9. Woods SW, Addington J, Cadenhead KS et al. Validity of the prodromal risk syndrome for first psychosis: findings from the North American Prodrome Longitudinal Study. *Schizophr Bull* (in press).
10. Cannon TD, Cadenhead K, Cornblatt B et al. Prediction of psychosis in youth at high clinical risk: a multisite longitudinal study in North America. *Arch Gen Psychiatry* 2008;65:28-37.