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

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LETTER TO THE EDITOR

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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 subthreshold 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 sub-syndromal 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.

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References