Psychosis risk syndrome is not prodromal psychosis

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1. Patient population
A variety of operational criteria have been suggested for the ‘psychosis risk syndrome’ (PRS), a condition that has been re-labelled as ‘attenuated psychosis syndrome’ in DSM-5. One common element of the various criteria is that the individual seeks treatment to relieve the distress and anguish that often accompanies the occurrence of psychotic-like experiences.[1] A study in China reported a prevalence of PRS of 4.2% among individuals who sought help at a psychological counseling center.[2] But – unlike persons with psychotic spectrum disorders—these individuals usually had fairly good insight and could differentiate real experiences from delusions or illusions, so they voluntarily sought help to understand their new, often frightening, experiences. In fact, only a small portion of individuals with psychotic-like experiences subsequently develop full-criteria psychotic disorders.[3] Unlike these individuals with PRS, persons with schizophrenia spectrum disorders usually lack insight and, thus, are unwilling to voluntarily seek treatment, especially during the early stages of the disorders. Based on these considerations, we contend that the PRS population seen in clinical settings is not the same as the ‘prodromal schizophrenia spectrum’ population, though individuals with PRS who have associated negative symptoms, impaired cognitive functioning, and non-psychotic symptoms are at a higher risk of developing schizophrenia than healthy controls.[4]

2. Diagnosis of psychosis risk syndrome
Currently, PRS is considered a transitional state useful for research purposes, not a clinical diagnosis. One of the most commonly used assessment tools for PRS, the Structured Interview for Prodromal Symptoms (SIPS) developed by McGlashan and colleagues,[5] identifies three PRS subtypes: attenuated positive symptoms syndrome, brief intermittent psychotic syndrome, and genetic risk and deterioration syndrome. Most research using the SIPS focuses on the developmental trajectory of the syndrome without stratification of results by PRS subtype. Individuals with PRS either develop full-blown psychotic disorders or remit, with virtually all transitions occurring within 10 years of the onset of the PRS.[4] Some individuals who previously met the operational criteria for PRS may have persistent residual symptoms (i.e., they don’t fully remit), but the PRS label is no longer appropriate because they no longer meet PRS criteria. Thus, PRS is a transitional state, it should not be misconstrued as a disorder.
3. Outcome of psychosis risk syndrome

The main purpose of the development of the PRS label was to allow for the earlier identification of persons with psychotic conditions, that is, prodromal psychosis. If psychosis is the result of a progressive deterioration in brain function, early intervention may provide opportunities to prevent or ameliorate the condition, so any operational criteria that identify prodromal cases would be useful. However, several long-term studies report that two-thirds of the individuals who meet criteria for PRS never develop a psychotic disorder. Fusar-Poli and colleagues[6] found that the risk of transition from PRS to psychotic disorders was 18% in 6 months, 22% in 12 months, 29% in 2 years, and 32% in 3 years. This is consistent with long-term follow-up studies which report that most PRS-to-psychosis transitions occur within 2 years of the onset of PRS.[4,7] Thus individuals with PRS are at higher risk of developing psychosis than persons without PRS, but only a minority of them progress to a psychotic disorder. So PRS should not be mislabeled or misconstrued as ‘prodromal psychosis’.

Another problem in considering PRS as a type of prodromal psychosis is that PRS may not be a predictor of deterioration in functioning—a primary component of the current definition of psychotic disorders. A study by Yung and colleagues[8] found that some individuals who transitioned from PRS to psychotic disorders retained high levels of functioning while other individuals with PRS who did not transition to psychotic disorders had serious impairments in functioning.[8] We conclude that PRS is not a sensitive predictor of psychotic disorders.

4. Intervention for psychosis risk syndrome

Due to the rather low conversion rate, the recommended clinical interventions for PRS and schizophrenia spectrum disorders are fundamentally different. Antipsychotics are the mainstream clinical intervention for schizophrenia spectrum disorders. In contrast, the clinical guidelines of the British National Institute for Health and Clinical Excellence (the NICE guidelines)[9] explicitly state that antipsychotics should not be used for either treatment or prevention among children or adolescents with PRS who do not meet the diagnostic criteria for psychotic disorders or schizophrenia. A meta-analysis on this issue by Van der Gagg and colleagues[10] recommends not using antipsychotics as first-line clinical intervention for individuals with PRS.

The recommended interventions for PRS are active monitoring and non-pharmaceutical psychotherapeutic behavioral interventions. The former intervention aims to reduce the duration of untreated psychosis (DUP) by rapidly identifying individuals who transition from PRS to a full psychosis. The latter intervention aims to prevent the transition to psychosis via integrated cognitive behavioral therapy, group therapy, or family therapy. The outcomes of these specialized types of therapy are usually superior to those of supportive psychological counseling.[11]

In summary, we think the current level of evidence is not sufficient to consider PRS a subtype of schizophrenia spectrum disorders. Moreover, individuals with PRS should not be treated using the same clinical protocols as those employed for schizophrenia spectrum disorders.

Conflict of interest

Authors declare no conflict of interest related to this article.

Funding

The preparation of this forum was supported by National Natural Science Foundation of China (81201043, 81171267, 61102020, 81261120410, 81361120403), Shanghai Municipal Natural Science Foundation (12ZR1448400), National Key Clinical Disciplines at Shanghai Mental Health Center (Office of Medical Affairs, Ministry of Health, 2011-873; OMA-MH, 2011-873).
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(received, 2014-12-02; accepted, 2015-01-09)

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