Tutorial Assignment 3

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OPRNET001

PSY3011S: Clinical Psychology II

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Introduction

Attenuated Psychosis Syndrome (APS) is a construct which attempts to describe an individual who is in the earliest stages of a psychotic disorder, when symptoms have begun to manifest but before they have reached the severity threshold of a full disorder such as Schizophrenia (American Psychiatric Association [APA], 2013; Corcoran et al., 2021; Mahli and Bell, 2019; Zachar et al., 2020). Without delving too deeply into the history, APS was developed in an effort to identify the early signs of psychosis development, and to provide treatment in order to mitigate the harm it causes and inhibit its development (Carpenter, 2020; Corcoran et al., 2021; Mahli and Bell, 2019; Zachar et al., 2020). Originally, this syndrome was added to an index of the DSM-5 which signalled the need for more research. Recently, there have been calls for APS to be moved from this index into the main section of the DSM-5 in the next DSM revision, giving rise to heated debate regarding how wise this decision is (Carpenter, 2020; Corcoran et al., 2021; Mahli and Bell, 2019). As the background has been established, this paper will now outline the argument for the inclusion of APS, the criticism and responses, and then conclude with a possible remedy for the challenges APS faces.

Support and Criticism for APS

There are a number of immediate benefits to moving APS into the main section of the DSM-5. In the case of a normal psychosis diagnosis, there has usually been an enormous amount of harm to the client by the time the first psychotic episode occurs (Carpenter, 2020; Zachar et al., 2020). The primary benefit of APS is that it facilitates the detection and treatment of developing psychotic symptoms before they get to this point, saving the client from serious complications and improving the chances for better results (Carpenter, 2020; Zachar et al., 2020). Additionally, APS in the main DSM-5 will be a signal for more focused research and clinician education on the period before a full psychotic disorder is clearly recognisable, and a move away from framing psychosis as all-or-nothing and discrete (Carpenter, 2020; Corcoran et al., 2021; Zachar et al., 2020).

However, there have been a number of issues raised with regards to APS. Firstly,

the criteria for APS are ambiguous, only requiring the presence of a single symptom for diagnosis and relying on a vaguely defined threshold of a client's insight into their symptom's non-reality (Mahli and Bell, 2019). Essentially, there is no way to clearly define the edges of APS, making its use practically difficult (Mahli and Bell, 2019). This compounds a second issue: ambiguity makes misdiagnosis and false-positives more likely, leading to potential sources of stigma (Corcoran et al., 2021; Mahli and Bell, 2019; Zachar et al., 2020). Further some clinicians may treat a diagnosis of APS as a *de facto* diagnosis of Schizophrenia, and treat it as such with inappropriate prescription of antipsychotic medication, even in cases where clinical guidelines refrain from their use (Carpenter, 2020; Corcoran et al., 2021; Mahli and Bell, 2019; Zachar et al., 2020). Finally, there have been issues raised regarding the reliability of APS as a predictor of Schizophrenia or other psychotic disorder. Specifically, only a fraction of clients who could be diagnosed with APS (around a quarter) go on to develop Schizophrenia, and of this fraction there is a large number who functionally qualify for a full psychotic disorder diagnosis already that is just being held at the levels of attenuated psychotic symptoms by use of antipsychotic medication already (Mahli and Bell, 2019; Raballo et al., 2020).

Inclusion in the main section of the DSM-5 will open the door to the development of proper training and treatment guidelines (Carpenter, 2020; Corcoran et al., 2021; Zachar et al., 2020). This will in turn reduce the liklihood of misdiagnosis as clinicians are properly trained, and will allow treatment guidelines to solidify and prevent the inappropriate prescription of antipsychotic medication (Carpenter, 2020; Corcoran et al., 2021; Zachar et al., 2020). Furthermore, stigma seems to be more associated with the symptoms of psychotic disorder than the label of psychotic disorders, so the risk regarding an APS diagnosis should still be lower than with a full psychotic disorder, and in all cases should be managed with education (Carpenter, 2020; Corcoran et al., 2021). Finally, even a 10% of individuals with APS progressing to a full psychotic disorder is still significantly higher than the general population, and further those that do not progress may either be worth studying for what they can tell us about resiliency or otherwise may have been helped by treatment for APS in the first

place (Carpenter, 2020; Corcoran et al., 2021). Otherwise, research does suggest that there is a high enough reliability and validity rate to begin locking down a diagnosis definition for APS (Raballo et al., 2020).

Conclusion

While there is solid criticism of the move to add APS to the main section of DSM-5, reasonable responses have been offered and recent research has closed many of the gaps that previously existed. As discussed above, there are still challenges that proponents of APS face, but these are not insurmountable. While there are always issues associated with adding a new diagnosis to the DSM, the inclusion of APS seems to be a net positive for the reasons outlined above. Doing so will also put it in a position where the final gaps in the criteria can be closed and research can be converted into practical clinical guidelines.

References

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