Attenuated Psychosis Syndrome –DSM-5 (Conditions for Further Study)

Proposed Criteria

A. At least one of the following symptoms is present in attenuated form, with relatively intact reality testing, and is of sufficient severity or frequency to warrant clinical attention:

   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech.

B. Symptom(s) must have been present at least once per week for the past 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.

E. Symptom(s) is not better explained by another mental disorder, including a depressive or bipolar disorder with psychotic features, and is not attributable to the physiological effects of a substance or another medical condition.

F. Criteria for any psychotic disorder have never been met.

Diagnostic Features

Attenuated psychotic symptoms, as defined in Criterion A, are psychosis-like but below the threshold for a full psychotic disorder. Compared with psychotic disorders, the symptoms are less severe and more transient, and insight is relatively maintained. A diagnosis of attenuated psychosis syndrome requires state psychopathology associated with functional impairment rather than long-standing trait pathology. The psychopathology has not progressed to full psychotic severity. Attenuated psychosis syndrome is a disorder based on the manifest pathology and impaired function and distress. Changes in experiences and behaviors are noted by the individual and/or others, suggesting a change in mental state (i.e., the symptoms are of sufficient severity or frequency to warrant clinical attention) (Criterion A). Attenuated delusions (Criterion A1) may have suspiciousness/persecutory ideational content, including persecutory ideas of reference. The individual may have a guarded, distrustful attitude. When the delusions are moderate in severity, the individual views others as untrustworthy and may be hypervigilant or sense ill will in others. When the delusions are severe but still within the attenuated range, the individual entertains loosely organized beliefs about danger or hostile intention, but the delusions do not have the fixed nature that is necessary for the diagnosis of a psychotic disorder. Guarded behavior in the interview can interfere with the ability to gather information. Reality testing and perspective can be elicited with nonconfirming evidence, but

the propensity for viewing the world as hostile and dangerous remains strong. Attenuated delusions may have grandiose content presenting as an unrealistic sense of superior capacity. When the delusions are moderate, the individual harbors notions of being gifted, influential, or special. When the delusions are severe, the individual has beliefs of superiority that often alienate friends and worry relatives. Thoughts of being special may lead to unrealistic plans and investments, yet skepticism about these attitudes can be elicited with persistent questioning and confrontation.

Attenuated hallucinations (Criterion A2) include alterations in sensory perceptions, usually auditory and/or visual. When the hallucinations are moderate, the sounds and images are often unformed (e.g., shadows, trails, halos, murmurs, rumbling), and they are experienced as unusual or puzzling. When the hallucinations are severe, these experiences become more vivid and frequent (i.e., recurring illusions or hallucinations that capture attention and affect thinking and concentration). These perceptual abnormalities may disrupt behavior, but skepticism about their reality can still be induced.

Disorganized communication (Criterion A3) may manifest as odd speech (vague, metaphorical, overelaborate, stereotyped), unfocused speech (confused, muddled, too fast or too slow, wrong words, irrelevant context, off track), or meandering speech (circumstantial, tangential). When the disorganization is moderately severe, the individual frequently gets into irrelevant topics but responds easily to clarifying questions. Speech may be odd but understandable. At the moderately severe level, speech becomes meandering and circumstantial, and when the disorganization is severe, the individual fails to get to the point without external guidance (tangential). At the severe level, some thought blocking and/or loose associations may occur infrequently, especially when the individual is under pressure, but reorienting questions quickly return structure and organization to the conversation.

The individual realizes that changes in mental state and/or in relationships are taking place. He or she maintains reasonable insight into the psychotic-like experiences and generally appreciates that altered perceptions are not real and magical ideation is not compelling. The individual must experience distress and/or impaired performance in social or role functioning (Criterion D), and the individual or responsible others must note the changes and express concern, such that clinical care is sought (Criterion A).+

Associated Features Supporting Diagnosis

The individual may experience magical thinking, perceptual aberrations, difficulty in concentration, some disorganization in thought or behavior, excessive suspiciousness, anxiety, social withdrawal, and disruption in sleep-wake cycle. Impaired cognitive function (Seidman et al. 2010) and negative symptoms (Woods et al. 2009) are often observed. Neuroimaging variables distinguish cohorts with attenuated psychosis syndrome from normal control cohorts with patterns similar to, but less severe than, that observed in schizophrenia (Fusar-Poli et al.

2012b; Howes et al. 2009; Koutsouleris et al. 2009a; Koutsouleris et al. 2009b). However, neuroimaging data is not diagnostic at the individual level.+

Prevalence

The prevalence of attenuated psychosis syndrome is unknown. Symptoms in Criterion A are not uncommon in the non-help-seeking population, ranging from 8%–13% for hallucinatory experiences and delusional thinking (van Os et al. 2009). There appears to be a slight male preponderance for attenuated psychosis syndrome.+

Development and Course

Onset of attenuated psychosis syndrome is usually in mid-to-late adolescence or early adulthood (Woods et al. 2009). It may be preceded by normal development or evidence for impaired cognition, negative symptoms, and/or impaired social development. In help-seeking cohorts, approximately 18% in 1 year and 32% in 3 years may progress symptomatically and met criteria for a psychotic disorder (Fusar-Poli et al. 2012a). In some cases, the syndrome may transition to a depressive or bipolar disorder with psychotic features, but development to a schizophrenia spectrum disorder is more frequent. It appears that the diagnosis is best applied to individuals ages 15–35 years (Fusar-Poli et al. 2012a). Long-term course is not yet described beyond 7–12 years (Fusar-Poli et al. 2012a).+