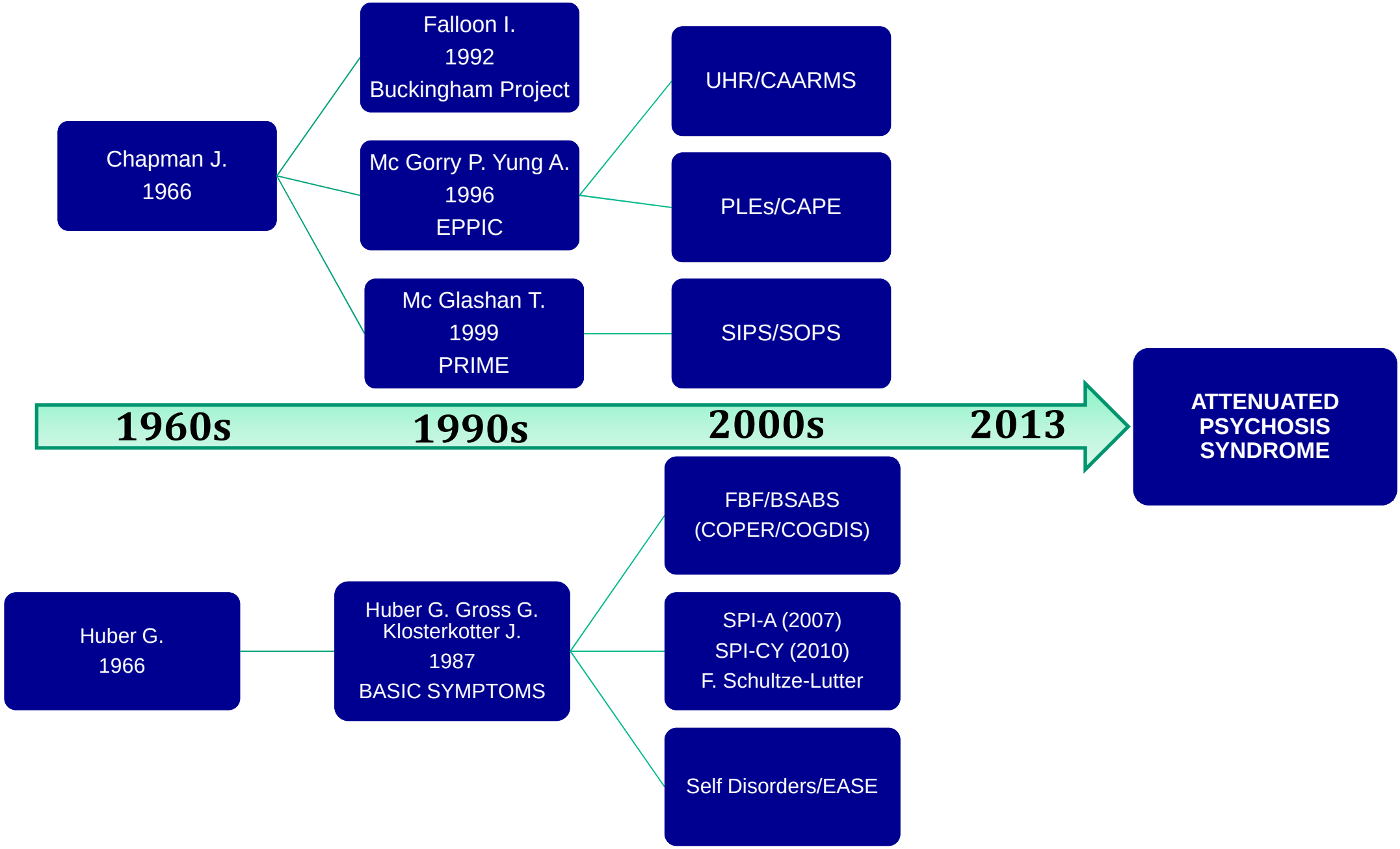
“ATTENUATED PSYCHOSIS SYNDROME”: DALLA PREISTORIA AL DSM-V


Chapman J.
1966
Falloon I.
1992
Buckingham Project
Mc Gorry P. Yung A.
1996
EPPIC
Mc Glashan T.
1999
PRIME
UHR/CAARMS
PLEs/CAPE
SIPS/SOPS
1960s
1990s
2000s
2013
ATTENUATED PSYCHOSIS SYNDROME
Huber G.
1966
Huber G. Gross G. Klosterkotter J.
1987
BASIC SYMPTOMS
FBF/BSABS
(COPER/COGDIS)
SPI-A (2007)
SPI-CY (2010)
F. Schultze-Lutter
Self Disorders/EASE

Schizophrenia Research 150 (2013) 31–35

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Attenuated psychosis syndrome in DSM-5

Ming T. Tsuang [a,b,c,*], Jim Van Os [d,e], Rajiv Tandon [f], Deanna M. Barch [g], Juan Bustillo [h], Wolfgang Gaebel [i], Raquel E. Gur [j], Stephan Heckers [k], Dolores Malaspina [l,m], Michael J. Owen [n], Susan Schultz [o], William Carpenter [p]

*The terms "Attenuated Psychosis Syndrome describe a condition with **recent onset psychotic-like symptoms** and clinically relevant **distress and disability**.*

These patients also are at significantly increased risk of conversion to a full-blown psychotic disorder (Fusar Poli et al., 2012)

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The issues for inclusion of APS in appendix (section 3)

- ✓ *A majority of individuals with current APS have some other current psychiatric comorbidity*
- ✓ *A substantial proportion of individuals with APS do not go on to develop major psychopathology.*
- ✓ *It is unclear if APS represents a trait or state vulnerability (for increased risk of development of a psychotic disorder).*
- ✓ *It is unclear if the distress and/or disability resulting in help-seeking behavior by this group of individuals is related to APS or the "comorbid" mental disorder*

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2. Proposed clinical criteria for APS

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

1. delusions/delusional ideas
2. hallucinations/perceptional abnormalities
3. disorganized speech/communication

B. Symptoms in Criterion A must be present at least once per week for the past month.

C. Symptoms in Criterion A must have begun or worsened in the past year.

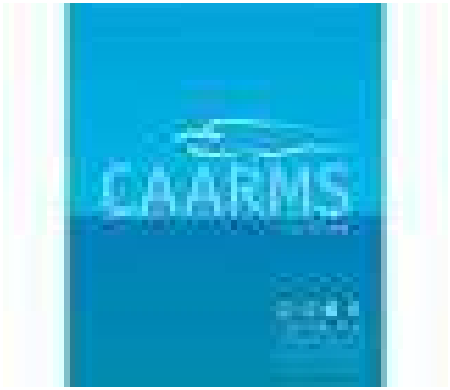
D. Symptoms in Criterion A are sufficiently distressing and disabling to the individual and/or legal guardian to lead them to seek help.

E. Symptoms in Criterion A are not better explained by any other DSM-5 diagnosis, including substance-related disorders.

F. Clinical criteria for a psychotic disorder have never been met (McGlashan et al., 2010).

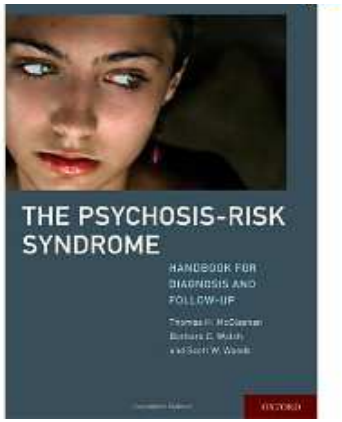
2. Strumenti per la valutazione

Comprehensive Assessment for At Risk Mental States

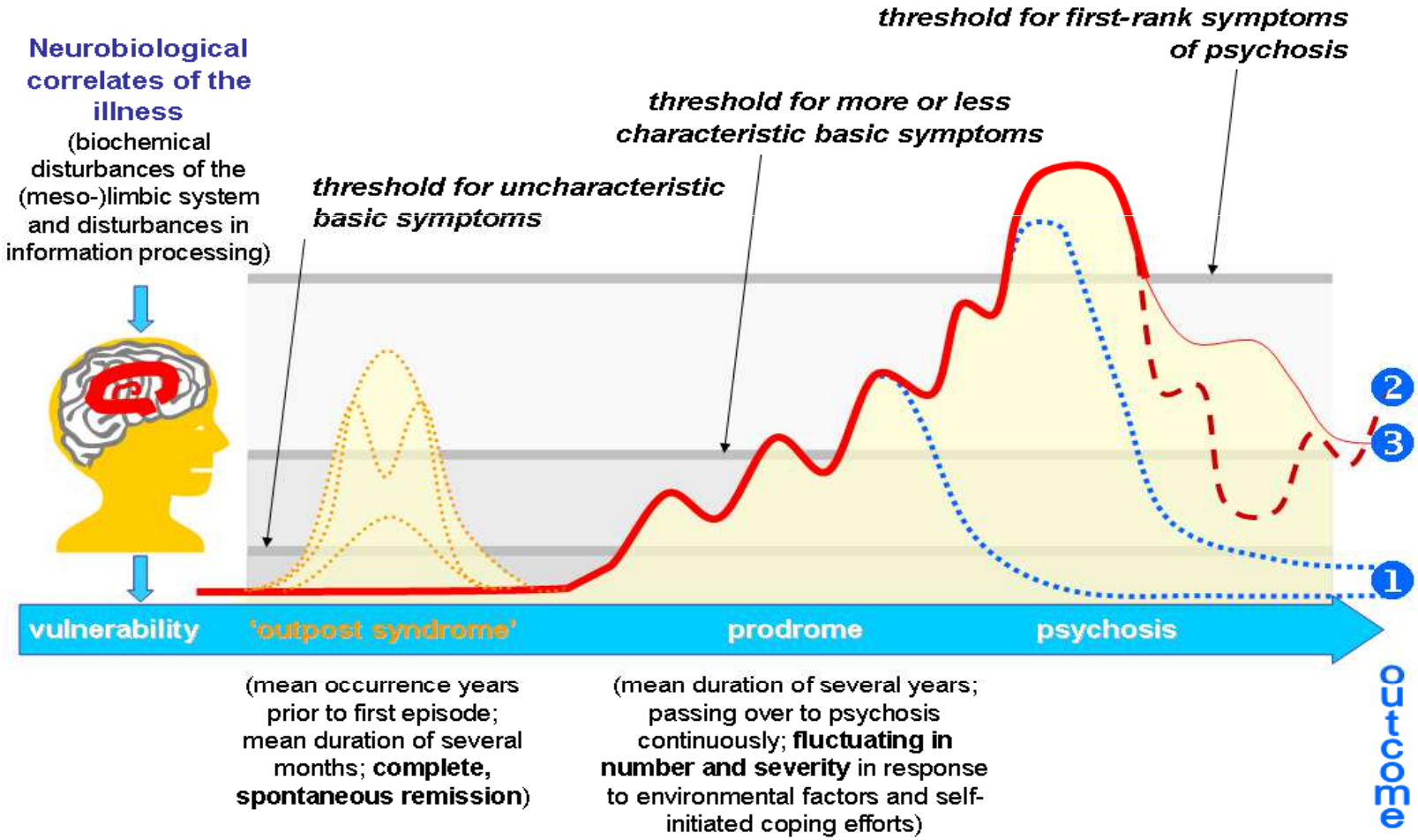


SPI-A

The Psychosis-Risk Syndrome: Handbook for Diagnosis and Follow-Up



3. La transizione da "Aps" ad esordio psicotico



Frauke Schultze-Lutter

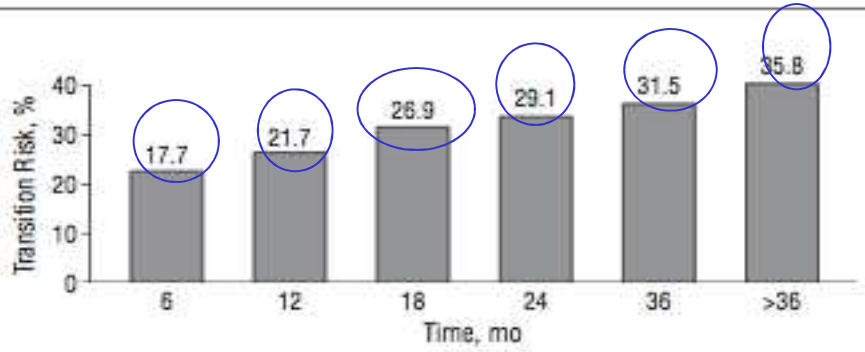
Schizophrenia Bulletin vol. 35 no. 1 pp. 5–8, 2009

Predicting Psychosis

Meta-analysis of Transition Outcomes in Individuals at High Clinical Risk

Paolo Fusar-Poli, MD, PhD; Ilaria Bonoldi, MD; Alison R. Yung, PhD; Stefan Borgwardt, PhD;
Matthew J. Kempton, PhD; Lucia Valmaggia, PhD; Francesco Barale, PhD;
E[illegible]

ARCH GEN PSYCHIATRY/VOL 69 (NO. 3), MAR 2012



No. of Studies	Follow-up, mo	Transition Risks, 95% CI
9	6	17.7 (12.3-24.9)
13	12	21.7 (16.6-27.8)
4	18	26.9 (19.5-35.9)
12	24	29.1 (23.2-35.7)
6	36	31.5 (23.8-35.0)
4	>36	35.8 (29.6-42.5)

P<.001 for all.

Figure 2. Meta-analyses of transition risks from clinical high risk to full psychosis at different time points of follow up.

"The risk of developing psychosis in HR patients increases as the follow-up time increases, at least within the first 3 years of presentation"

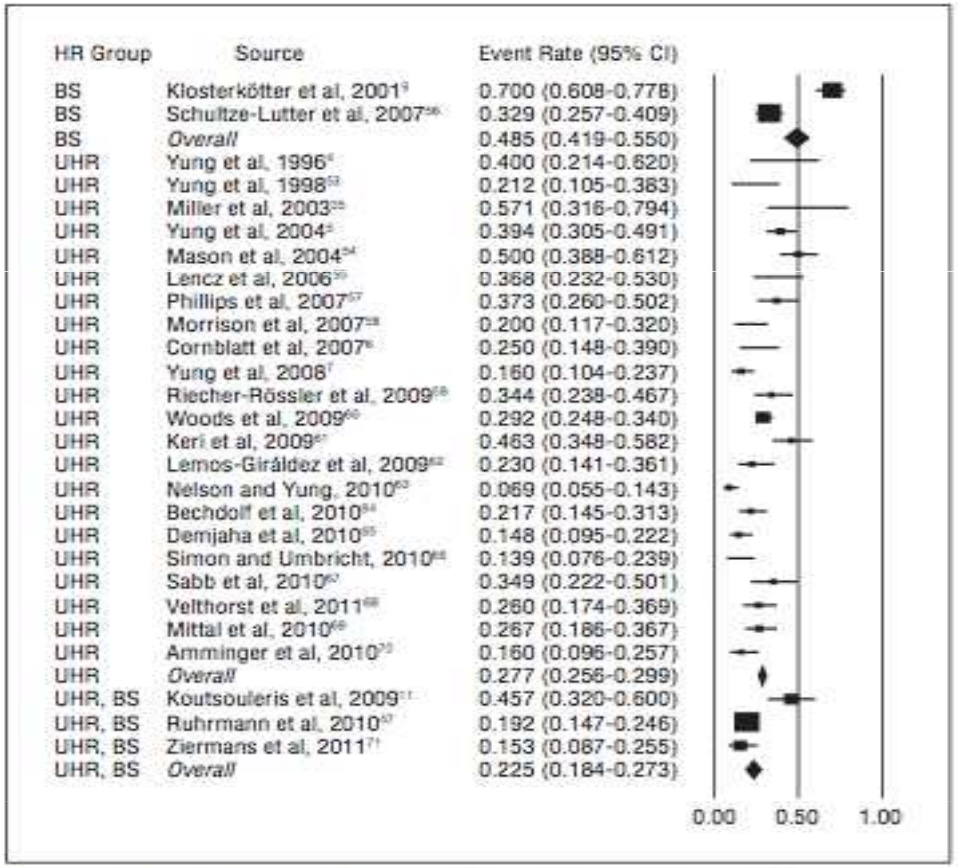


Figure 5. Effect on inclusion criteria (BS, UHR, and UHR plus BS) of the transition risks. Studies are stratified by inclusion criteria with point estimates and 95% CI. Test for between-groups variability, $Q = 46.56_2$; $P < .001$. BS indicates basic symptoms; and UHR, ultra high risk.

CAARMS versus **SIPS**:

CAARMS:27.4% [95% CI, 24.6%-30.4%]

SIPS: 28.1% [25.1%-31.3%]

(**CAARMS** vs **SIPS**, Q=0.12; P= .73).

CanJPsychiatry 2013;58(1):32–40

In Review

The Significance of At-Risk Symptoms for Psychosis in Children and Adolescents

Benno Graf Schimmelmann, MD[1]; Petra Walger, MD[2]; Frauke Schultze-Lutter, PhD[3]

The early detection and treatment of people at risk for psychosis is currently regarded as a promising strategy in fighting the devastating consequences of psychotic disorders. Currently, the 2 most broadly used sets of at-risk criteria, that is, ultra-high risk (UHR) and basic symptom criteria, were developed mainly in adult samples. We review the data regarding the presence and relevance of at-risk symptoms for psychosis in children and adolescents. The few existing studies suggest that attenuated psychotic symptoms (APS) and brief limited intermittent psychotic symptoms (BLIPS) do have some clinical relevance in young adolescents from the general population. Nevertheless, their differentiation from atypical psychotic symptoms or an emerging schizotypal personality disorder, as well as their stability and predictive accuracy for psychosis, are still unclear. Further, standard interviews for UHR criteria do not define a minimum age for the assessment of APS and BLIPS or guidelines as to when and how to include information from parents. APS and basic symptoms may be predictive of conversion to psychosis in help-seeking young adolescents. Nevertheless, the rate and timing, and thus the required observation time, need further study. Moreover, no study has yet addressed the issue of how to treat children and adolescents presenting with at-risk symptoms and criteria. Further research is urgently needed to examine if current at-risk criteria and approaches have to be tailored to the special needs of children and adolescents. A preliminary rationale for how to deal with at-risk symptoms for psychosis in clinical practice is provided.

CanJPsychiatry 2013;58(1):32–40

In Review

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Highlights

- Research into the early detection of psychosis has predominantly been carried out in adults and older adolescents, with little consideration of possible special requirements in children and younger adolescents; hence neither the rates and timing of conversion to psychosis and other disorders in children and younger adolescents fulfilling current at-risk criteria are clear nor the clinical relevance of, and treatment options for, at-risk symptoms in help-seeking or general population samples of this age group.
- Children and adolescents' at-risk symptoms should be assessed together with comorbid psychiatric syndromes and disorders, as well as psychosocial and neuropsychological functioning; however, owing to the current lack of knowledge in this age group, risk of conversion to psychosis should not be communicated to children and adolescents and their families, or it should be done very carefully.
- More benign treatment options that increase resilience, such as stress reduction, cognitive-behavioural therapy, social skills training, healthy lifestyle, no alcohol and (or) illicit drugs, and sleep hygiene, as well as targeted treatment of comorbid psychiatric syndromes, including ADs, may be preferrable to cognitive therapy, which focuses only on APS and BLIPS, and to antipsychotic treatment, owing to the higher risk of side effects in children and adolescents.

“ATTENUATED PSYCHOSIS SYNDROME”: DALLA PREISTORIA AL DSM-V

Table 1. Demographic and Clinical Differences at Baseline Between Clinical High-Risk Subjects With Good and Poor Outcome

Characteristic	No. (%)					
	Social Outcome			Role Outcome		
	Good (n = 48)	Poor (n = 44)	*P* Value	Good (n = 47)	Poor (n = 45)	*P* Value
Age, y, mean (SD)	15.90 (2.30)	16.02 (2.04)	.79	16.30 (2.30)	15.60 (2.01)	.13
Estimated current IQ, mean (SD)	106.07 (15.05)	100.49 (16.77)	.10	105.65 (16.95)	101.06 (14.88)	.14
Education, y, mean (SD)	9.60 (2.29)	9.84 (2.02)	.60	10.04 (2.24)	9.38 (2.04)	.17
Female	20 (41.7)	14 (31.8)	.39	20 (42.6)	14 (31.1)	.29
Right handed	43 (89.6)	35 (79.5)	.25	41 (87.2)	37 (82.2)	.57
Parental SES low[a]	2 (4.2)	4 (9.3)	.42	2 (4.3)	4 (9.1)	.43
White	42 (87.5)	32 (72.7)	.11	39 (83.0)	35 (77.8)	.60
Hispanic	4 (8.3)	9 (20.5)	.14	3 (6.4)	10 (22.2)	.04
First-degree relative with psychotic disorder	1 (2.1)	5 (11.4)	.10	2 (4.3)	4 (8.9)	.43
Schizotypal personality disorder	3 (6.2)	5 (11.4)	.47	4 (8.5)	4 (8.9)	>.99
SOPS score, mean (SD)						
Positive symptoms	8.33 (3.92)	9.30 (3.83)	.24	8.11 (4.03)	9.51 (3.62)	.08
Negative symptoms	11.11 (4.84)	15.53 (5.92)	<.001	11.94 (5.34)	14.56 (6.00)	.03
Total disorganization	5.01 (4.37)	7.44 (3.82)	.002	4.99 (3.58)	7.00 (3.71)	.002
General	8.80 (4.37)	8.72 (3.79)	.93	8.17 (4.32)	9.37 (3.76)	.16
Global functioning score, mean (SD)						
Social	6.60 (1.36)	5.45 (1.36)	<.001	6.09 (1.32)	6.02 (1.63)	.84
Role	5.92 (2.04)	5.27 (2.00)	.13	6.23 (2.05)	4.96 (1.83)	.002
Global assessment of functioning score, mean (SD)	47.52 (8.73)	44.70 (7.40)	.10	47.64 (8.67)	44.64 (7.48)	.08
DSM-IV diagnoses						
Mood[b]	33 (68.8)	25 (56.8)	.28	34 (72.3)	24 (53.3)	.08
Anxiety[c]	28 (58.3)	25 (56.8)	>.99	29 (61.7)	24 (53.3)	.53
Substance[d]	6 (12.5)	3 (6.8)	.49	3 (6.4)	6 (13.3)	.31
Medication at testing						
No medication	26 (54.2)	22 (50.0)	.85	24 (51.1)	24 (53.3)	.84
Antipsychotics	9 (18.8)	10 (22.7)	.80	11 (23.4)	8 (17.8)	.61
Antidepressants	13 (27.1)	15 (34.1)	.50	17 (36.2)	11 (24.4)	.26
Anxiolytics	5 (10.4)	4 (9.1)	>.99	5 (10.6)	4 (8.9)	>.99
Mood stabilizers	3 (6.2)	1 (2.3)	.62	2 (4.3)	2 (4.4)	>.99
Stimulants	2 (4.2)	1 (2.3)	>.99	1 (2.1)	2 (4.4)	.61
Other medications[e]	0	1 (2.3)	.48	0	1 (2.2)	.49
Time to last follow-up, y, mean (SD)	3.12 (1.60)	2.80 (1.61)	.34	2.90 (1.63)	3.03 (1.60)	.70

Prediction of Functional Outcome in Individuals at Clinical High Risk for Psychosis

JAMA Psychiatry Published online September 4, 2013

Table 2. Scores on the Neurocognitive Domains for Clinical High-Risk Subjects With Good and Poor Social Outcome

Score	Mean (SD)		$F_{2,152}$ Value	*P* Value	Cohen *f*[a]	Post hoc Contrasts[b]
	Good Social (n = 48)	Poor Social n = 44)				
Verbal memory	−0.51 (1.13)	−1.43 (1.39)	19.94	<.001	0.50	HC>PO, GO; PO>GO
Working memory	−0.42 (1.17)	−0.92 (1.28)	9.05	<.001	0.33	HC>PO
Executive function	−0.25 (1.29)	−1.63 (2.9)	11.37	<.001	0.39	HC>PO; PO>GO
Sustained attention	−0.35 (1.18)	−0.99 (1.4)	9.35	.003	0.34	HC>PO, GO
Processing speed	−1.08 (2.03)	−2.02 (2.44)	18.18	<.001	0.46	HC>PO, GO; PO>GO
Motor speed	−0.39 (1.22)	−0.42 (1.38)	2.92	.002	0.16	HC>PO; PO>GO
Visuospatial processing	−0.62 (1.34)	−0.87 (1.78)	5.56	.005	0.26	HC>PO
Language	−0.43 (1.46)	−1.12 (1.58)	9.08	<.001	0.34	HC>PO; PO>GO

Table 3. Scores on the Neurocognitive Domains for Clinical High-Risk Subjects With Good and Poor Role Outcome

Score	Mean (SD)		$F_{2,152}$ Value	*P* Value	Cohen *f*[a]	Post hoc Contrasts[b]
	Good Role (n = 47)	Poor Role (n = 45)				
Verbal memory	−0.58 (1.01)	−1.33 (1.56)	19.12	<.001	0.47	HC>PO; PO>GO
Working memory	−0.40 (1.24)	−0.96 (1.25)	8.75	<.001	0.35	HC>PO
Executive function	−0.18 (1.29)	−1.76 (2.87)	11.36	<.001	0.45	HC>PO; PO>GO
Sustained attention	−0.48 (1.26)	−0.68 (1.45)	6.15	.003	0.24	HC>PO; PO>GO
Processing speed	−0.75 (1.29)	−2.44 (2.91)	17.56	<.001	0.58	HC>PO, GO
Motor speed	−0.09 (1.04)	−0.81 (1.50)	3.32	.06	0.31	...
Visuospatial processing	−0.62 (1.31)	−0.86 (1.79)	5.54	.01	0.27	HC>PO
Language	−0.34 (1.27)	−1.31 (1.77)	8.95	<.001	0.42	HC>PO; PO>GO

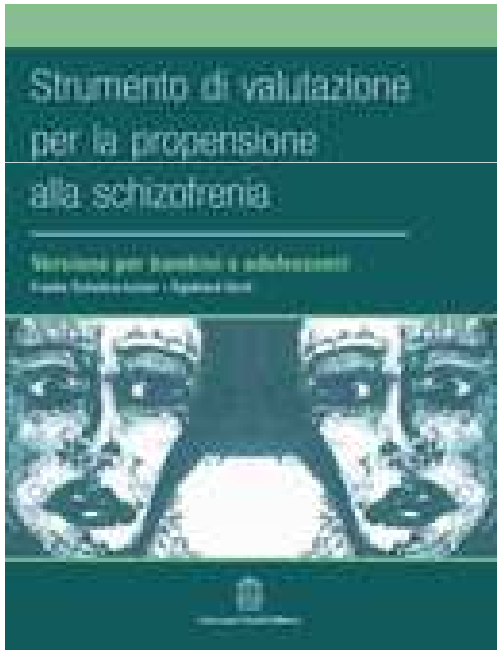
▪ Criticità per la diagnosi in adolescenza/preadolescenza

- ✓ *la maggior parte degli strumenti diagnostici disponibili sono stati validati sulla popolazione adulta*

- ✓ *i criteri utilizzati per gli adulti vengono applicati alla popolazione preadolescenziale ed adolescenziale anche se non è stata ancora pienamente verificata la loro attendibilità rispetto a questa fascia d'età.*

Ad oggi….

SPI-CY



Intervista Metacognitiva Child_Version

INTERVISTA PER LA VALUTAZIONE DELLA METACOGNIZIONE (IVAM_CHILD):

1- FASE PRELIMINARE

Domande di conoscenza per familiarizzare col bambino, durante le quali si valuta che tipo di linguaggio il bambino possiede, se fluente o meno.

In caso di linguaggio fluente si lascia che il bambino identifichi un **episodio negativo che riguarda una difficoltà con un'altra persona**; nel caso in cui il bambino mostri difficoltà lo si aiuta suggerendo i contesti interpersonali possibili (scuola, maestre, compagni, genitori, fratello/sorella, nonni).

2- NARRAZIONE LIBERA

"(nome bambino)*____parliamo un po' di quella situazione brutta che ti è successa ____* (indicare l'episodio riportato)*. Mi racconti un po' cosa ti è capitato? Se riesci cerca di raccontarmi tutto quello che ti ricordi così capisco meglio come sono andate le cose.*

É tutto chiaro? Se non hai capito qualcosa fammi pure delle domande"

Il racconto dovrebbe durare circa 15 minuti; siate parchi nel fare le domande. Lasciare che il bambino racconti la storia come meglio crede. Solo quando la narrazione è terminata, è possibile chiedere ulteriori informazioni su eventi, personaggi o luoghi specifici che sono stati approfonditi di meno; in ogni caso non bisogna mai chiedere al bambino di indagare aspetti che non ha menzionato spontaneamente nel suo racconto, se non attraverso le domande di approfondimento.

SPI-CY

- indaga la **tipologia**, **la frequenza** e l' **intensità** di quei **sintomi** che caratterizzano la **fase prodromica più precoce.**

Intervista Metacognitiva Child_Version

INTERVISTA PER LA VALUTAZIONE DELLA METACOGNIZIONE (IVAM_CHILD):

1- FASE PRELIMINARE

Domande di conoscenza per familiarizzare col bambino, durante le quali si valuta che tipo di linguaggio il bambino possiede, se fluente o meno.

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- Indaga il **funzionamento mentale** del singolo paziente in termini di **processi meta cognitivi**, ovvero di idee e credenze in base alle quali vengono interpretati e valutati i contenuti e processi mentali

- Aggiungere PACE 400 di Barnaby e cosa succede a chi non va in transizione di Lin

Criteri d'inclusione		
Sintomi psicotici attenuati (APS)	Presenza almeno di uno dei seguenti sintomi: • idee di riferimento • convinzioni errate o pensieri magici • disturbi della percezione • ideazione paranoide • pensieri ed eloquio bizzarri • comportamento e aspetto bizzarro	•Cambiamento nello stato mentale è presente per almeno una settimana e non più di 5 anni. •Frequenza dei sintomi: almeno diverse volte alla settimana.
Sintomi psicotici brevi limitati intermittenti ("BLIPS")	presenza di almeno uno dei seguenti sintomi: • idee di riferimento • pensieri magici • disturbi della percezione • ideazione paranoide • pensieri ed eloquio bizzarri	Durata dell'episodio meno di una settimana. I sintomi si risolvono spontaneamente. Il BLIPS deve essere comparso durante l'anno precedente
Tratti e fattori di stato a rischio	Parente di primo grado con una diagnosi di disturbo psicotico o di personalità schizotipica (secondo il DSM-IV)	La diminuzione della funzionalità deve essere comparsa durante l'anno precedente. *Yung AR et al. Psychosis prediction: 12-month follow up of a high-risk ("prodromal" group. Schizophrenia Research 2003; pag.24.*