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A Counselor's Role in Diagnosing the Proposed *DSM-5* Attenuated Psychosis Syndrome: A Pathway to Early Intervention or Iatrogenic Consequences?

Vanessa Jung Tirman and Ryan P. Melton

Jung Tirman, Vanessa, was a PsyD student at Antioch University, Santa Barbara and is currently a PsyD student at California School of Professional Psychology at Alliant University, Los Angeles. Jung's research interests include prodromal psychosis and early intervention, integration of mental health and medical primary care, health psychology and advocating for prescribing privileges for psychologists.

Melton, Ryan P., is faculty at Portland State University and is a recent PhD graduate from Oregon State University. He is the State of Oregon's Clinical Coordinator for the Early Assessment and Support Alliance (EASA) project, which is a legislative funded public health approach that integrates evidenced base practices with young people in the early stages of major psychotic conditions. He is a nationally recognized leader on early intervention with psychosis and also serves as the chair for the Oregon Board of Licensed Professional Counselors and Therapists. Melton's research interests include early interventions with major psychotic illnesses—especially exploring what treatments are most effective at each stage of illness and counselor preparation for complex differential *DSM* diagnosis.

Authors' Note: At the time of VISTAS acceptance of this paper, the American Psychiatric Association (APA) was considering APS (Attenuated Psychosis Syndrome) as a proposed diagnosis in the psychotic disorders section of the DSM-5. The APA recently made the decision to not include the new diagnosis with the psychotic disorders and moved it to section III of the DSM-5 for more research. The authors of this paper are supportive of this decision for reasons described in the paper. We do however feel that the paper maintains relevance because the of the current rise of early intervention programs for psychotic disorders across the country and the ongoing use of the Structured Interview for Psychosis Risk Syndromes (SIPS) tool by counselors to identify individuals who may be at risk of psychotic disorders.

Revisions are underway to release the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorder, DSM-5*, (American Psychiatric Association, 2012) One diagnosis that is being considered under the category of Schizophrenia Spectrum and other Psychotic disorders is Attenuated Psychosis Syndrome (APS). APS is considered a risk factor for major psychotic disorders such as schizophrenia and bipolar disorder. This article will focus on the role counselors play in the early diagnosis of at-risk patients and the importance of an accurate diagnosis. Additionally, the categorization of APS in the

DSM is considered in an effort to help prevent inappropriate diagnosis and potential resulting treatment failure. A literature review is presented on the diagnosis of APS by means of the Structured Interview for Psychosis-Risk Syndrome (SIPS)—currently the most heavily used assessment tool in the field for identifying those at-risk for schizophrenia spectrum disorders such as the purposed APS—as well as long term follow-up of APS patients and their outcomes. Discussion follows on the importance of counselors becoming well versed on the symptoms of APS to prevent inaccurately diagnosing this population of patients and potentially causing poor outcomes.

Introduction

Psychosis in general, and schizophrenia specifically, are among the most debilitating and difficult to treat disorders in mental health (Correll, Hauser, Auther, & Cornblatt, 2010). Identifying a patient with at-risk symptoms before the first episode of schizophrenia can be invaluable to the patient, clinician, and the community because the patient is treated early in the course of the disease where treatment is highly effective. After years of research it has been confirmed that at-risk symptoms for schizophrenia generally precede the first episode of psychosis, which results in the diagnosis of schizophrenia (Correll et al., 2010). At present however, the assessment and recognition of these symptoms for schizophrenia or APS remain under debate (Carpenter, 2009).

Research has shown that utilizing low dose antipsychotic medication, cognitive behavioral therapy, and having a supportive family and social environment are essential resources to recovery and reduction of trauma for a patient experiencing symptoms of APS (Lencz, Smith, Auther, Correll, & Cornblatt, 2003; McGlashan, Walsh, & Woods, 2010; Olsen & Rosenbaum, 2006; Portland Identification and Early Referral Program, 2009; S.Trevino, personal communication, November 18, 2010). At this time research shows that early detection of APS symptoms can achieve secondary and tertiary prevention, such as delaying the onset of psychosis and reducing suicide, but does not prevent schizophrenia from occurring (McGlashan, et al., 2010.)

There are various ways in which counselors can receive referrals to assess a patient for APS. The patient can be referred by a family member, a health care provider, a school administrator, a court order, another clinician, or by the patient directly. A clinical assessment encounter with the patient is then needed. The encounter should use a multi-method approach of clinical interviewing and assessment tests to diagnose and help place the patient in the appropriate treatment algorithm. At first referral to a clinician, the patient may not present with a need to assess for APS. Recognizing a broad marker for instability, such as multiple AXIS I diagnoses without clear criteria, may be an effective first clue that a patient may be exhibiting APS symptoms and warrant a diagnostic assessment.

One goal of this paper is to describe the current diagnostic tools for APS, especially the Structured Interview for Psychosis-Risk Syndrome, SIPS, (McGlashan, et al., 2010). The SIPS assessment tool is a comprehensive assessment tool that can be used in the field to diagnose early detection for schizophrenia and monitor symptom severity.

Evaluating the inclusion criteria of APS into the *DSM-5* under the diagnostic category of Schizophrenia Spectrum and other Psychotic Disorder is another purpose of this paper. Based on recent information provided by the American Psychiatric

Association's Task Force on DSM-5, dated April 27, 2012, the diagnosis of APS has been recommended for further research and proposed for Section III of the DSM-5. The authors agree with the direction that the DSM-5 task force has taken to require further research in this important diagnosis. Creating a diagnosis that treats prodromal psychosis as a precursor to schizophrenia and not a precursor for other well recognized disorders with psychotic features such as bipolar, trauma, and stressor-related disorders is a disservice and dangerous to the patient.

Literature Review

The SIPS is to be administered by trained clinicians of many mental health disciplines including clinicians and clinical researchers possessing at least a bachelor's degree (McGlashan et al., 2010). Tables 1-3, created by the present authors, summarizes what the SIPS assessment tool aims to achieve in assessing for and diagnosing APS based on *The Psychosis-Risk Syndrome: Handbook for diagnosis and follow up* (McGlashan et al., 2010). The SIPS is a semi-structured interview that is given by a clinician to a patient and their family members. The assessment process may take from 1 to 3 hours.

Clinicians administer the SIPS in three stages. The first section is the Presence of Psychotic Symptoms criteria (POPS) and is administered to rule out current or past psychosis in a patient. The second stage of the SIPS is the Criteria of Psychosis Risk Syndrome (COPS). It aims to identify if the patient exhibits one or more symptoms of the three types of Psychosis Risk Syndrome (PRS): Brief Intermittent Psychotic Syndrome, Attenuated Positive Symptom Syndrome (which is most similar to the criteria for the proposed *DSM-5* APS diagnosis), and Genetic Risk and Deterioration Syndrome. The third section, the Scale of Psychosis Risk Syndrome (SOPS), assesses the rate and severity of the PRS. The SOPS scale is listed first, in Table 1, which is out of sequence with the administering stages because the SOPS scale is used to evaluate the POPS and COPS.

The reliability and predictive validity of the SIPS tools has been researched (Correll et al., 2010; Lencz et al., 2003; McGlashan et al., 2010; Miller et al., 2003; Olsen & Rosenbaum, 2006). In a reliability study done by Miller et al. in 2002, raters administering the SIPS were 93% consistent in their assessment of whether subjects were at a baseline prodromal or non-prodromal state. The study listed the validity of the SIPS tools to predict patients developing a first episode of schizophrenia after baseline assessment of psychosis risk syndromes including APS. Predicting the onset of schizophrenic psychosis within 6 months after baseline the SIPS had an accuracy of 46% and 54% at 12 months.

Discussion

Accurate and early diagnosis of APS is critical to treating the patient appropriately and in obtaining the best therapeutic results. Currently a broad diagnosis of psychotic disorder not otherwise specified in the *DSM-IV-TR* is most often used when treating this APS population (American Psychiatric Association, 2000). However a psychotic disorder not otherwise specified diagnosis may not be specific enough to make treatment recommendations. Early recognition research has shown that patients

designated as at risk for psychosis can develop a range of diagnoses such as schizophrenia, bipolar disorder, post traumatic stress disorder, substance induced psychosis, or have no diagnosis (Rossler et al., 2001). Each of these diagnoses carries a different treatment protocol. If a new category is to be created in the *DSM-5* for Attenuated Psychosis Syndrome (McGlashan, et al., 2010), attention should be drawn to broadening the differential diagnosis assessment to prevent over or inaccurately diagnosing patients with APS and then subsequently inaccurately diagnosing those patients with a major psychosis syndrome. This is especially true with the ultimate diagnosis of schizophrenia in a patient who may have another cause of psychosis such as bipolar disorder.

A strong therapeutic alliance between the patient and clinician is also important to correctly assess for APS symptoms (McGlashan et al., 2010; Wong et al., 2009) and result in the potential for a more accurate diagnosis. If a patient does not feel safe in sharing their experiences with the clinician during evaluation, the results will not be accurate. A clinician's role is to help the patient in the reduction of trauma; therefore the clinician must use any assessment tool with sensitivity and patient focused actions in developing a therapeutic alliance.

There are over six assessment tools existing today that clinicians can use to identify APS symptoms (Olsen & Rosenbaum, 2006). The two most heavily used in the field are the Comprehensive Assessment of At-Risk Mental States (CAARMS) and the Structured Interview for Psychosis-Risk Syndrome (SIPS). The authors of *The Psychosis-Risk Syndrome Handbook for Diagnosis and Follow-up* and the developers of the SIPS tool explain the differences between these two assessment tools:

> CAARMS was originally crafted to be a diagnostic instrument. The SIPS on the other hand was designed to diagnose not only the risk syndromes but also the presence of or conversion to psychosis, and to rate the severity of risk symptoms longitudinally, i.e., to measure change with time and treatments. (McGlashan et al., 2010, p. 16)

The SIPS provides a clinician the ability to assess for APS symptoms as well as to rate the severity of the symptoms. The formal and lengthy process of administering the SIPS could be a challenge to the development of the therapeutic alliance.

Early intervention has shown to be invaluable in alleviating and reducing trauma experienced by a patient with APS symptoms. However, various tools can only be effective to use in assessing APS symptoms if a patient is open and honest in their responses during an evaluation by a clinician and a therapeutic alliance has been established prior to the assessment. This may be easier to establish with APS patients versus those with fully developed schizophrenia, as insight into their symptoms remains preserved.

Family members and friends that have a relationship with a patient experiencing APS symptoms can be resources to referring a patient to a clinician. However, in some cases family members do not recognize their loved ones are experiencing APS symptoms (Ruston, 2010; Smiley, Plotch, Oppenheim, & Vine Street Pictures, 2006). In order for clinicians to recognize and assess a patient for APS it is necessary that the patient be evaluated with valid and reliable tools such as the SIPS.

Sometimes fear and stigma exist that prevent a patient from being evaluated or sharing their psychosis experience with others (Smiley et al., 2006; Wong et al., 2009). It

takes insight, education, and awareness of changes in the behavior in a patient that can warrant an evaluation by a clinician. Stigma and the negative effects on families and patients and the effect on early detection or assessment is challenging for clinicians because the clinicians are often not trained to recognize psychosis until it meets *DSM* criteria for schizophrenia. Therefore, accurate and early diagnosis of APS is important in placing the patient into the most effective treatment protocol whether it is schizophrenia or another cause of psychosis. An effective treatment strategy based upon an accurate diagnosis is critical for the best outcome.

Despite the advantages of early recognition, there are also risks that all mental health clinicians, including professional counselors, should be aware of when working with this population. A diagnosis of APS, accurate or not, may result in a referral to a physician whom may prescribe high dose medications. The popular wisdom that high dose antipsychotic medications are the obvious choice for people experiencing APS symptoms, based on their effectiveness with those patients who met full diagnostic criteria for schizophrenia, may have iatrogenic consequences. Alternative psychosocial counseling interventions may be more appropriate for patients with APS symptoms (Kane, Krystal, & Correll, 2003). Bentall and Morrison (2002) suggested that the use of antipsychotic medications at all might be dangerous because of the aversive side effects. Further, their effect on the developing brain of adolescents, the age in which APS criteria is most likely to be met, is yet unknown (Bola, Kao, & Soydan, 2011).

Counselors may offer strength in the areas of accurate empathy and rapport building for patients with APS symptoms. Diagnostic training is crucial for APS and is limited at this time (Council for Accreditation of Counseling & Related Educational Programs, 2011). It is essential for counselors to receive postgraduate training on early recognition tools such as the SIPS to aid in proper diagnosis, and ultimately treatment, which maximizes benefits and minimizes risks for the patient.

Any assessment tool could be ineffective, regardless of training if a patient is not willing to seek professional attention. As a greater goal, our culture might work toward minimizing any existing negative stigmas regarding schizophrenia and toward encouraging accurate early recognition of symptoms. There is a sense of great optimism and hope in the research being done today on APS, that this greater goal may be reached; hence, the consideration for this diagnosis as a new category in the *DSM-5*. The hope is the final decision on inclusion of APS has the desired effect of early recognition and more appropriate treatment as opposed to misdiagnosis and further perpetuation of an already poorly understand condition. Properly trained and sensitive counselors may be helpful in achieving this goal.

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Table 1.

Scale of Psychosis Risk Syndrome (SOPS)

Sections of the SOPS	**Subsections**	**Measures**	**Summary**
Positive symptoms	1. Unusual thought content/ Delusional Ideas 2. Suspiciousness/Persecutory Ideas 3. Grandiose Ideas 4. Perceptual Abnormalities/Hallucinations 5. Disorganized Communication	Several interview questions are asked by the clinician to the patient requiring a "N" or no, "NI"=no information, or "Y" yes response. If a "Y" response is given for a question additional questions are asked to obtain more information. Two types of severity scales: 1. For positive symptoms ranging from 0 (absent) to 6 (severe and psychotic) 2. For negative, disorganized and general symptoms ranging from 0 (absent) to 6 (Extreme)	The total combined SOPS score for the four sections do not affect the diagnosis of PRS but are taken to quantify the range and severity of the PRS symptoms. The SOPS scales are used in the COPS and POPS sections of the SIPS. Number of questions requiring a "Y,N,NI" response per section: Positive Symptoms: 48 Negative Symptoms: 13 Disorganization Symptoms: 9 General Symptoms: 4 Number of Severity Scale questions administered per section: Positive Symptoms: 5 Negative Symptoms: 6 Disorganization Symptoms: 4 General Symptoms: 4
Negative symptoms	1. Social Anhedonia 2. Avolition 3. Expression of Emotions and Self 4. Experience of Emotions and Self 5. Ideational Richness 6. Occupational Functioning		
Disorganization symptoms	1. Odd Behavior of Appearance 2. Bizarre Thinking 3. Trouble with Focus and Attention 4. Impairment in Personal Hygiene		
General symptoms	1. Sleep Disturbance 2. Dysphoric Mood 3. Motor Disturbances 4. Impaired Tolerance to Normal Stress		

Table 2.

Presence of Psychotic Symptoms Criteria (POPS)

Assessment types	Measures	Summary
Initial screening (pre-POPS)	Intuitive freedom given to a trained clinician to assess for psychosis in the past or present. Questions would include but are not limited to history of trauma, abuse, learning disability, developmental history, substance abuse, recent changes, family history of psychosis, and any extraordinary life circumstances.	Clinicians can rule out current and past episodes of psychosis and should not use the SIPS if a patient meets these criteria.
Positive Symptoms scale for SOPS and Frequency/Duration/Urgency	1. The patient scores "6" on any one of the SOPS positive symptoms questions. 2. At least one symptom above has occurred for over one month at a minimum frequency of four days per week and one hour of those days.	A positive assessment for a current or past psychosis requires both measures to be met.

Table 3.

Criteria of Psychosis-Risk Syndrome (COPS)

Types of PRS	Length or frequency of symptoms	Measures	Summary
Brief Intermittent Psychotic Syndrome (BIPS): Psychotic symptoms that are very brief and recent.	Began in the past three months, is present several minutes in one day with a frequency of at least once per month.	1. The patient scores "6" on any one of the SOPS Positive Symptoms section questions. 2. If any of the "6" scores have occurred in the last three months. 3. If both of the above have occurred for at least several minutes in one day at least once this month. 4. Lastly that the patient does not better fit into any other AXIS I or II DSM IV diagnosis.	The patient would be diagnosed with BIPS if they met the four condition measures.
Attenuated Positive Symptom Syndrome (APSS): Positive attenuated psychosis-risk level symptoms that are severe and frequent.	Began in the past year or rates on a scale of severity that is one level higher than 12 months ago, frequency of at least once per week in the past month at the current level of intensity.	1. The patient scores "3-5" on any one of the SOPS positive symptoms questions. 2. If any of the "3-5" scores begun within the past year or currently rate one point higher than last year. 3. If both of the above have occurred at least once per week in the past month. 4. The patient does not better fit into a DSM-IV AXIS I or II disorder.	A diagnosis of APSS would be given if the patient meets the four criteria measures.
Genetic Risk and Deterioration Syndrome (GRDS): Combined genetic risk for a schizophrenic disorder and a recent deterioration of functionality.	Functional deterioration in the last month.	1. First-degree relative has had a psychotic disorder or the patient meets criteria for Schizotypal Personality disorder based on the DSM-IV. 2. A current 30% drop in GAF, taken from the DSM-IV, scores relative to the highest GAF in the last 12 months.	A positive diagnosis for GRDS would be given if both measures are met.