The Near Babylonian Speech Confusion in Early Detection of Psychosis

Frauke Schultze-Lutter*,1, Benno G. Schimmelmann1, and Stephan Ruhrmann2

1Research Department, University Hospital of Child and Adolescent Psychiatry, Bolligenstrasse 111, CH-3000 Bern 60, Switzerland; 2Department of Psychiatry and Psychotherapy, University of Cologne, Cologne, Germany

*To whom correspondence should be addressed; tel: +41-31-932-8564, fax: +41-31-932-8569, e-mail: frauke.schultze-lutter@kjp.unibe.ch

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It is barely 15 years since, in 1996, the issue theme of Schizophrenia Bulletin (Vol 22, 2) “Early Detection, and Intervention in Schizophrenia” signified the commencement of this field of research. Since that time the field of early detection research has developed rapidly and it may be translated into clinical practice by the introduction of an Attenuated Psychosis Syndrome in Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-5) (www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=412#). Attenuated psychotic symptoms (APS) had first been suggested as a clinical predictor of first-episode psychosis by the Personal Assessment and Crisis Evaluation (PACE) Clinic group as part of the ultrahigh risk (UHR) criteria.1 The term ultrahigh risk became broadly accepted for this set of criteria for imminent risk of developing psychosis in the late 1990s. The use of the term “prodrome” for a state characterized by at-risk (AR) criteria was criticized as a retrospective concept inevitably followed by the full-blown disorder.1 Although alternative terms have been suggested, prodrome is still used in prospective studies (eg, promromally symptomatic, potentially or putatively prodromal, prodrome-like state/symptoms). Some alternative suggestions such as prepyschotic state/symptoms, subthreshold psychotic symptoms, early psychosis, subsyndromal psychosis, hypopsychosis, or subpsychosis were short-lived. Other terms still in use include UHR, at-risk mental state (ARMS), AR, high risk, clinical high risk (CHR), or early and late AR state. Further, the term psychotic-like experiences (PLEs) has recently (re-)entered early detection research. This variety of terms would not be a problem if the underlying concepts and criteria were identical. But this is not the case.

UHR criteria including APS and brief limited intermittent psychotic symptoms (BLIPS) as well as a state-trait risk factor combination are generally assessed in clinical interviews with the Structural Interview for Psychosis-Risk Syndromes (SIPS)2 and the Comprehensive Assessment of At-Risk Mental States (CAARMS, version 12/2006),3 respectively. However, their UHR definitions differ, particularly in frequency and duration criteria and the role of functional deficits. Besides differences related to assessment instruments, some groups introduced certain variations of UHR criteria. For example, the CHR criteria only include the APS criterion of the UHR criteria and, additionally, attenuated negative symptoms according to the SIPS.4 Other groups extended APS and/or BLIPS by SIPS disorganized symptoms5,6 or modified the state-trait criterion.6,7 Further, UHR criteria are increasingly combined with basic symptom criteria.6,7 Also, AR criteria vary within centers across time; eg, the PACE clinic has refined the UHR criteria several times. That such differences are not trivial is illustrated in a small general population sample, where UHR criteria according to the SIPS were met by 2%, the more liberal duration criteria of the CAARMS 01/2002 by 10%, and the CAARMS 12/2006 criteria with a newly introduced functional deficit criterion by 0%.8

The situation is comparable with regard to PLEs. Within the recent discussion about an Attenuated Psychosis Syndrome, concerns were voiced that APS might only reflect common, potentially nonpathological phenomena in the general population.9 These concerns arose from epidemiological studies reporting high prevalence rates of psychotic symptoms and PLEs, respectively, in the general population. The term "psychotic-like experiences" was initially used in reference to Strauss’ continua hypothesis.10 Challenging the dichotomous nature of positive psychotic symptoms in clinical samples, Strauss11 had proposed the conceptualization of a continuum between “normal” experiences and “true,” severe hallucinations and delusions. He also suggested a likewise continuum from mental health to schizophrenia including intermediate states with “some “subschizophrenic” level of dysfunction”11(p585) and symptoms, including schizotypal symptoms. This continua hypothesis
was later extended by van Os and colleagues\(^\text{12}\) to the general population. For the description of points on the psychotic continuum, criteria were put forward such as degree of conviction, degree of preoccupation or implausibility, or brevity.\(^\text{10,11}\) Accordingly, PLEs had to be assessed in an in-depth clinical interview. Thus, in this early definition and operationalization, PLEs were indeed much comparable to nowadays APS.\(^\text{1}\)

However, scientific language is in constant flux and meaning of terms can change. This has occurred for the PLEs: Nowadays, in epidemiology-related literature, the term PLEs mainly refers to psychotic symptoms in the absence of psychotic disorders\(^\text{13}\) and/or to doubts about their true psychotic nature due to an uncertainty about the validity of their assessment.\(^\text{14}\) The latter is due to the fact that PLEs in recent epidemiological studies are generally assessed by self-rating questionnaires or comparable assessments such as fully standardized interviews by lay persons.\(^\text{14}\) Mainly for differences between patients' and experts' understanding, which become obvious only within the clinical dialogue, the validity of self-reported PLEs is already dubious for psychotic symptoms.\(^\text{14}\) Furthermore, self-reported PLEs have to be regarded as an even less valid measure of APS since their assessments generally target psychotic symptoms but not schizotypal features. In consequence, self-reported PLEs from current epidemiological studies cannot be compared with APS and BLIPS assessed in clinical interviews or even equated with the PLEs in the conceptualization of Strauss.\(^\text{11}\)

Nevertheless, study results and terms are increasingly mixed as the following random example shows: “PLEs are used to identify individuals considered to be at Ultrahigh Risk (UHR) of, or prodromal for, psychotic disorder.” Thus, the nomenclature in early detection research increasingly lacks clarity with the ever-new emergence of terms and conceptualizations.

Such an unsound terminology is certainly not unique to this field. In genetic counseling, Vos and colleagues\(^\text{15}\) identified 361 terms denoting the frequently occurring genetic variants of uncertain clinical significance in only 227 articles. Yet, “words are important instruments for the […] counselor, whose main task is transmitting information,” and the “specific wording may influence how patients and other professionals understand, interpret, memorize, and attach consequences to the result.”\(^\text{15,16}\) Thus the great variety of terms and their lack of validity and reliability may, in clinical settings, create inconsistencies between professionals and misunderstandings in patients.\(^\text{15}\) Further, in research settings, this Babylonian speech confusion may blur sources of discordance between findings and constrict their interpretation, thus impeding scientific progress. Although in early detection of psychosis research, the number of terms for a positive test result on current AR criteria is not (yet) as high, the negative clinical and scientific consequences are certainly comparable.

To resolve the current confusion, an international consensus catalogue of terms and their definition as well as guidelines of how to describe aberrant criteria should be developed. Until then, research reports should give sufficient information on the definition of AR criteria and their assessment—including the version of scales when versions differ significantly—to allow a thorough evaluation of the comparability of samples. Accordingly, before a new category like the Attenuated Psychosis Syndrome is introduced into DSM-5, any operationalization proposed for such a category should be carefully evaluated with regard to its factual support by current studies.

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References


