Global Journal of Intellectual & Developmental Disabilities
ISSN: 2575-8586

Juniper Publishers
key to the Researchers

Opinion
Volume 13 Issue 1 - December 2023
DOI: 10.19080/GJIDD.2023.13.555855

Glob J Intellect Dev Disabil

The Prodromal States of Psychosis and their Evaluation

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Submission: July 20, 2023; **Published:** December 18, 2023

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Abstract

Psychotic disorders are among the world's leading causes of disability, with a prevalence of more than 1 percent, and schizophrenia can be considered the most severe and disabling mental disorder because of its major impact on the personal and social sphere, but also on health care costs. The World Health Organization (WHO) reports that there are approximately 24 million people worldwide who suffer from schizophrenia at any level. The age of onset has gradually decreased over the years, from late adolescence and young adulthood to early adolescence in many cases. The course is almost always chronic with a variable pattern between Glare-ups and phases of partial remission. Several consequences complicate the picture: the delayed and inadequate clinical response, the functional disability of the patient, the stigma that affects those with it, and the immense difficulties for the family. Recently, research has particularly focused on this phase to identify prevention and early intervention strategies that can contribute to the improvement of the clinical course and quality of life of the patient and family members.

Keywords: At Risk Mental State; Psychotic; Young adulthood; Schizophrenia; Psychopathologic

Abbreviations: WHO: World Health Organization; FEP: First Onset Psychotic; UHR: Ultra-High Risk; FHR: Familial High Risk; APS: Attenuated Psychotic Symptoms; COPER: Cognitive-Perceptive Basic Symptoms; COGDIS: Cognitive Disorders

Introduction

Schizophrenia is a severe mental disorder with a chronic course and unknown etiopathogenesis, with serious individual and social implications and whose risk appears to be associated mostly with genetic factors and their interaction with environmental factors [1]. From a clinical point of view, Schizophrenia is characterized by symptoms belonging to three main clusters: positive symptoms, negative symptoms and cognitive symptoms. The age of onset has gradually decreased over the years, from late adolescence and young adulthood to early adolescence in many cases. The course is almost always chronic with a variable pattern between Glare-ups and phases of partial remission. Recent data report that at the time of the Girst episode, 75% of treated subjects can achieve symptomatic remission at 6 months, but only 20% achieve satisfactory functional recovery; most have low quality of life. According to numerous studies inaugurated by Yung and coworkers, onset is preceded by the so- called prodromal phase [2], which is associated with subthreshold symptomatology compared with that of the full- blown phase of the disorder. Recently, research has particularly focused on this phase to identify prevention and early intervention strategies that can contribute to the improvement of the clinical course and quality of life of the patient and family members [3]. Scientific evidence, moreover, indicates that most clinical and psychosocial deterioration occurs in the Girst 5 years of illness and how this time window is crucial for starting treatment [4]. It is widely acknowledged that schizophrenia is considered the tip of an iceberg, the terminal phase of a course involving transformations in psychopathological dimensions, such that four main developmental stages can be determined: premorbid, prodromal, acute, and (eventually) remission. The onset of a psychotic disorder may be preceded by weeks, months, or years of psychological and behavioral abnormalities, including disturbances in cognition, emotions, perception, communication, motivation, and sleep. This model, proposed by McGorry [5], is now indispensable at the clinical level because it identifies specific diagnostic procedures, pharmacological, psychological and social

interventions that are useful for each stage of the disorder, aimed primarily at improving the timing of interventions in psychiatry assessed in terms of their ability to prevent or delay progression from the earliest to the most advanced stages of the disorder.

Stages of Psychosis Illness

Specifically, the premorbid stage includes individuals at risk of developing schizophrenia due to genetic and environmental factors. The prodromal stage includes the critical phase of varying duration from days to years (5 years) marked by worsening occupational, personal, and social functioning compared with the previous stage. In addition, symptomatology of subthreshold frequency, duration and intensity appears during this period compared with the overt stage of the illness, which, therefore, is difficult to diagnose [6]; [7]. The individual in this period begins to experience a process of change and deterioration at the subjective and behavioral levels. Identifying this phase is crucial for early intervention and for modifying the prognosis of future and eventual illness. However, several difficulties arise in identifying the prodromal phase, both conceptual and operational in nature. Firstly, the term prodrome is a retrospective concept and is used after the onset of the actual disorder [8] and is therefore difficult to identify; secondly, the symptomatology present in this phase is entirely nonspecific and therefore traceable to multiple psychopathological pictures (from anxiety disorders to mood disorders); and thirdly, given the indeterminacy of the symptomatology, even more information on its characteristics needs to be found. The study of the prodromal stage, then, and of all the risk factors that might increase the possibility of developing frank psychosis at this stage, could help predict the probability of transition into frank psychosis from a stage of vulnerability and at the same stage of vulnerability in more at-risk individuals, helping to define possible indicators of transition. Finally, we discuss First Onset Psychotic (FEP) when the illness begins with moderate to severe symptoms, initial neurocognitive deficiencies, and potential functional decline. By contrast, when substantial deterioration now occurs, we speak of a chronic clinical picture. Because of the indefiniteness and non-specificity of the concept of prodrome, Yung and coworkers [6] outlined criteria for identifying ultra-high risk (UHR) for the development of psychosis, designed to identify young people who have an imminent risk of experiencing a Girst psychotic episode. Coining the term "mental state at risk" was a way to address the fact that "prodrome" is a retrospective concept and does not imply an inevitable progression to full disorder, unlike the term "prodrome." In the development of the ARMS criteria (or UHR ultra-high-risk criteria) [9], clinical features that indicate a high and imminent risk of psychotic disorder are described, so that identification and treatment of these phenomena will reduce the risk of disorder psychotic disorder. The idea behind the criteria and the name "Mental State at Risk" is that the syndrome designates the risk of psychosis at the time the person is experiencing such symptoms, determining a risk factor for psychotic disorder. Specifically, based on the characteristics of intensity, frequency, and duration of the presented symptoms, the "UHR criteria" are divided into 3 categorization groups.

The FHR (familial high risk) category denotes people who have only a familial for psychosis by having a Girst-degree relative with psychiatric pathology and specifically psychotic or mood disorders; but who at the symptomatic level do not present no manifestation or vulnerability and from a clinical point of view are healthy controls in all respects. Familial risk is determined by the fact that these people share a percentage of DNA [10] with the relative with the disorder. It has been thought, therefore, that an adolescent with a family history of schizophrenia was at higher risk of develop psychosis than an individual without such a family history, and that a marked and prolonged decline in functioning could likely indicate the development of a psychotic disorder. The APS (attenuated psychotic symptoms) category involves the presence of nonspecific symptomatic manifestations (anxiety, sleep disturbances, mood decline) and specifically psychotic symptomatology (e.g. dubious persecutory ideas or hearing background noises or whispers) in an attenuated form. The BLIPS category (group of briefs, limited and intermittent psychotic symptoms) reveals that, even in the period prior to a frank episode of psychosis, psychotic symptomatology can occur in short, intermittent, and time-limited episodes. Basic symptoms, Girst defined by Huber in 1980, indicate features experienced exclusively by the subject and are therefore not recognizable from the outside.

They mainly concern subjective deficit features, the experiential equivalents of behaviorally defined negative symptoms. They have been shown to occur in the prodromal phase of schizophrenia, as well as in the state of deficit schizophrenia. It has also been shown that some basic symptoms (cognitive, language and perceptual). Instruments have been designed to measure baseline symptoms in subjects considered at risk for psychotic disorders [11]. Symptoms of baseline, specifically, are subclinical, subthreshold, subjectively experienced disorders that affect instincts, affect, stress tolerance, thinking, language, perception, and motor skills. They are different from the mental states recognized by the patient as being part of his or her way of being and are not observable by others. They can occur in the pre-psychotic stages and contribute to the identification over time of several psychopathological and functional factors in young people at very high risk for psychosis. They may also be present in the relapse stages, in the acute inter- and post-psychotic phases, and in the psychotic episode itself. To manage such changes, they require the individual experiencing them to implement strategies of coping frequently. They represent, therefore, the immediate psychopathological expression of the underlying organic disorder of psychosis and therefore are termed "basic." With respect to the UHR criteria, they are not necessarily observable by others, the patient perceives them as coming from within and maintains

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unchanged thought content. They have been, therefore, defined two partially overlapping groups of basic symptoms for the definition of the prodromal phase with related criteria, the Cognitive-Perceptive Basic Symptoms (COPER) and the Cognitive Disorders (COGDIS).

Conclusion

The World Health Organization (WHO) reports that there are approximately 24 million people worldwide who suffer from schizophrenia at any level. The age of onset has gradually decreased over the years, from late adolescence and young adulthood to early adolescence in many cases. The course is almost always chronic with a variable pattern between Glare-ups and phases of partial remission. Several consequences complicate the picture: the delayed and inadequate clinical response, the functional disability of the patient, the stigma that affects those with it, and the immense difficulties for the family. Much of the clinical and social deterioration of psychotic individuals is established within the Girst years after onset, which indicates that early intervention in psychotic onset is needed to achieve rapid remission of symptoms, prevent deterioration of functioning, improve coping and adaptive skills, and provide, to the patient and his family, accurate information about the origins, evolution, and risk factors for possible relapse of the disorder.

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