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CPAN - A novel transdiagnostic dimensional approach to the assessment of psychotic disorders

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Introduction: Classification of mental disorders evolved greatly over time, as DSM and ICD dominated both research and everyday practice in the past decades. DSM-5 was planned to represent biological features of psychiatric disorders and include results of genetic and imaging studies in the criteria. Unfortunately, this goal couldn't be fulfilled, since, although there were promising results, evidence wasn't strong enough to fully support the biological background of the currently used diagnostic categories. One possible explanation for this discrepancy is that biological disturbances don't represent the somewhat artificial categorisation of these disorders. Many of the leading symptoms in psychotic disorders are nowadays considered as lying on a spectrum, such as autism, affective and psychotic spectrum disorders. Despite that, DSM-5 still describes schizophrenia, schizoaffective disorder and bipolar disorder as separate entities, however there can be major overlaps in the leading symptoms, moreover symptoms are not necessarily stable over time and can show fluctuations. It should be mentioned though that subgroups of schizophrenia in DSM-5 had been abolished and catatonia is considered as a trans-diagnostic specifier, moreover in ICD-11 certain symptoms can be added as symptoms specifiers to an existing diagnosis of primary psychotic disorder.
Objectives: Our aim was to establish a new trans-diagnostic, dimensional scale to assess the most important symptoms amongst patients with psychotic disorders. This scale is meant to represent the long-term clinical presentation and not a cross-sectional picture of a current state. We believe that long-term trajectories of these symptoms may be more connected to underlying biological features, such as genetic load (i.e. polygenic risk scores) and imaging results than the currently used diagnostic criteria. We think it is very important to create a tool, which is straightforward and short enough, so can be realistically used in everyday clinical work. This could provide important real-life data, which give us information about our patients from a different angle than the currently used diagnostic systems.
Methods: We have created the CPAN scale based on the current symptom specifiers of ICD-11 and the Clinician-Rated Dimensions of Psychosis Symptom Severity, which is an "emerging measure" for DSM-5 and also took into consideration our own clinical experience.
Results: The new tool measures 4 symptoms (catatonia, psychosis, affective symptoms and negative symptoms) on a scale of 5 (0-4). We have also put in specifiers to be able to characterize patients more precisely, and output measures (suicidal risk, functionality) to open the way for further analysis.
Conclusions: We tried to establish a novel symptom scale to help assessing patients with psychotic symptoms in everyday clinical work. Our plan is to test the validity of CPAN in the near future.

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Ultra-High-Risk that do not transition to psychosis. What happens?

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Introduction: Speaking prospectively we use the concept of "at risk mental state" (ARMS) to describe the state in which a person has a heightened risk of developing a psychotic disorder. Young people who are experiencing ARMS can be more precisely defined as being at ultra-high-risk of psychosis using a specific set of criteria known as the UHR criteria.
Objectives: To clarify the concept of ultra-high-risk individuals and to characterize the clinical and functional characteristics and general psychopathology of those individuals that do not transition to psychosis during the follow-up period.
Methods: Research on UpToDate using the terms "Ultra-High-Risk"; "psychosis", "transition".
Results: Recent literature has suggested that less than 30% of those who meet established criteria for being at Clinical-High-Risk of psychosis (CHR-P) go on to develop a psychotic illness. It is therefore of crucial importance and relevance to assess and clarify what happens to high-risk individuals who do not transition to psychosis, who make up the vast majority.
One of the most recent studies (NAPLS-2) that encompassed 764 of CHR-P individuals who were followed for 2 years, concluded that 278 did not transition to psychosis during the follow-up period. Three clinical outcomes were recorded: 1 group had experienced a psychopathological remission (39.57%); the other kept symptomatic but not currently meeting criteria for a prodromal risk syndrome (33.45%); the third group had a prodromal progression (26.98%). The study concluded among others that although the remission group had improved social functioning at 2 years compared with the other groups, they were still functioning below the healthy control group.
Another meta-analysis that included a total of 2756 CHR-P individuals with a mean duration of follow-up of 30.7 months evaluated several clinical outcomes in CHR-P that didn't transitioned to psychosis and between CHR-P non-transitioning versus those transitioning to psychosis. It concluded that CHR-P that do not transition to psychosis have an overall improvement of symptoms (APS, negative, depressive) and functioning at follow-up compared to baseline.
Conclusions: The occurrence of a first psychotic episode is often devastating for the patient and their family, especially given its usual onset in adolescence and early adulthood. This is a critical period in the individual's development as a person, and disorders at this stage can threaten the potential for a productive and inclusive adult life. Studies have suggested that less than 30% of individuals classified as UHR actually develop a psychotic disorder.
However, little is known about the individuals belonging to this group who do not transition to psychosis. We therefore consider it is relevant to clarify the clinical and functional outcomes of this group of individuals.

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