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EARLY INTERVENTION IN PSYCHOSIS: FROM A CLINICAL STRATEGY TO A POSSIBLE DIAGNOSTIC CATEGORY [1]

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ABSTRACT. In psychiatry, the possibilities of intervention in the risk for development of mental disorders are now receiving greater attention, motivating researches and causing controversies. Among the several investigations about risk and psychiatric categories that have been conducted in the international scenario, proposals intended to previously detect and intervene in the development of psychosis stand out. Programs for early detection of psychosis have two objectives: to reach patients living the first psychotic break and patients considered to be at risk mental state. Despite the controversy about the at risk mental state, with the preparation of a new version of the DSM, the possibility of creating a specific category that could identify the risk for psychosis was pondered. This article analyzed the path of the early intervention in psychosis, starting with the emergence of the actions within the context of clinical enhancement in the first break, going through the controversial systematization of the notion of at risk mental state, finally coming to the formalization of the proposal of a new diagnostic category during the preparation of the DSM-5.

Keywords: Early intervention; psychosis; psychiatry.

INTERVENÇÃO PRECOCE NA PSICOSE: DE ESTRATÉGIA CLÍNICA A POSSÍVEL CATEGORIA DIAGNÓSTICA

RESUMO. No campo psiquiátrico, as possibilidades de prevenir o risco de desenvolver transtornos mentais começam a reunir interesse, motivar pesquisas e provocar controvérsias. Entre as diversas investigações sobre risco e categorias psiquiátricas que vêm sendo conduzidas no cenário internacional destacam-se as propostas destinadas a detectar e intervir precocemente no desenvolvimento da psicose. Os programas de detecção precoce da psicose têm como objetivo atingir duas categorias de pacientes: os que vivem o primeiro surto psicótico e aqueles considerados em estado mental de risco ou pré-psicóticos. Apesar da controvérsia em torno do estado mental de risco, com a elaboração de uma nova versão do DSM aventou-se a possibilidade de criar uma categoria específica que identificasse o risco para a psicose. Neste artigo analisamos as propostas de intervenção precoce na psicose de estratégia clínica dividindo essa análise em três etapas: 1- a do surgimento das ações no contexto de refinamento da clínica do primeiro surto; 2- a da sistematização controversa da noção de estado mental de risco; 3- a da formalização da proposta de nova categoria diagnóstica durante a elaboração do DMS-5..

Palavras-chave: Intervenção precoce; psicose; psiquiatria.

INTERVENCIÓN TEMPRANA EN LA PSICOSIS: DE LA ESTRATEGIA CLÍNICA A UNA POSIBLE CATEGORÍA DIAGNÓSTICA

RESUMEN. En el campo de la psiquiatría, las posibilidades de intervención sobre el riesgo de desarrollar trastornos mentales comienzan a provocar interés, motivar la investigación y causar controversias. Entre las muchas investigaciones sobre riesgo y categorías psiquiátricas que se han realizado a nivel internacional, se destacan las propuestas para detectar e intervenir tempranamente en el desarrollo de la psicosis. Los programas para la detección temprana de la psicosis tienen doble objetivo: llegar a los pacientes que viven el primer episodio psicótico y a los pacientes considerados en el estado mental de riesgo o pre-psicóticos. A pesar de la

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controversia que rodea el estado mental de riesgo, con el desarrollo de una nueva versión del DSM, se ha previsto la posibilidad de crear una categoría específica para identificar el riesgo de psicosis. En este artículo, se analiza la transición de la intervención temprana en la psicosis de estrategia clínica, a partir del inicio de las acciones en el marco del perfeccionamiento del primer brote clínico, pasando por la sistematización de la controvertida noción de estado mental de riesgo y llegando a la formalización de la propuesta de una nueva categoría diagnóstica durante la preparación del DMS-5.

Palabras-clave: Intervención temprana, psicosis, psiquiatría.

Over the last few decades, we have observed the emergence and increase of proposals of assessment, intervention and management of sickening risks for several pathologies. Aiming to delay, minimize or prevent damages to health, these proposals have been configuring what some authors understand as a culture of risk in health, which would provoke important transformations in the way diseases are known, handled and experienced, with special emphasis to chronic pathologies and to those involving behavioral disorders (Crawford, 2004; Castel, 1987, 1991; Castiel, 1999; Castiel; Diaz, 2007; Aronowitz, 2009; Rose, 2010; Rose; Abi-Rached, 2013; Dumit, 2012). In psychiatry, similarly, the possibilities of intervention in the risk for development of mental disorders start to receive some attention, to motivate researches and to cause controversies.

Among the many investigations about risk and psychiatric categories being conducted in the international scenario, proposals intended to detect and early intervene in the development of psychosis stand out. Known as early psychosis*,* the movement of the late 1980's and early 1990's emerges in a context of reformulation of clinical strategies aimed at initial cases of psychosis and at investigations about the period of untreated psychosis (Lieberman & Fenton, 2000; Clarke & O'Callaghan, 2003; McGorry, Edwards, Mihalopoulos, Harrigan, & Jackson, 1996; McGorry, 2005, 2011; Hafner & Mauer, 2006; Marshall & Rathbone, 2011; Vyas & Gogtay, 2012). As investigations and discussions about the results achieved with the implementation of the first programs advance, the proposal of effectively detecting and early intervening in the risk for development of psychosis starts to gain ground. Currently, researches are being developed through big clinical investigation projects in centers for research and services, in workgroups of the International Early Psychosis Association (IEPA), and in studies promoted by the World Health Organization (WHO).

Programs for the early detection of psychosis have two objectives: to reach patients experiencing a psychotic break and patients considered to be in the at risk mental state, or as pre-psychotic. In the first case, intervention intends to prevent the long period of untreated psychosis, and to reduce the damages such periods bring to the life of the patients, characterizing a specification of clinical mental health services that seeks to refine and enhance care instruments. In the second case, intervention has as targets adolescents and young adults that do not present expressive symptoms of the disease, but, according to clinical protocols of the IEPA, would be at risk of developing psychosis. In this case, which is especially interesting to us, intervention would have an anticipating character, typical of preventive interventions or, in the current vocabulary, of risk assessment and management, and would have as a fundamental objective the prevention of the disease formation itself.

The discussions on the at risk mental state and on the preventive possibilities linked to it were not restrict to the sphere of the psychiatric clinic, of the research or of the organization of mental health services. Despite the controversy about the notion, with the preparation of a new version of the Diagnostic and Statistical Manual of Mental Disorders, the DSM, the possibility of creating a specific category that identified the individuals at risk for psychosis was pondered. Such proposal, presented in 2010 during the review process that precedes the publishing of the new version of the manual, reunited defenders, people interested in the formalization and, consequently, in the expansion of the possibilities of use of the notion, but also

mobilized several critics in a heated debate largely held through electronic means.

In this article we intended to analyze the transition of the early intervention in psychosis from a clinical strategy to a possible diagnostic category. We will start with the appearance of early intervention actions within the context of the refinement of the clinic of the first episode, going through the controversial systematization of the notion of at risk mental state, and coming to the formalization of the proposal of a new diagnostic category during the preparation of the DMS-5. In this path, we will discuss the innovative proposal of early intervention, the main arguments of the debate on the at risk mental state and the process of public negotiation of the proposed category. Finally, we intend to make considerations about the disputed preparation process of the diagnostic categories in psychiatry and about the recent application of the risk logic to the field.

THE EMERGENCE OF EARLY INTERVENTION ACTIONS IN PSYCHOSIS

The proposal of early intervention for psychosis appears in a context of reorganization and expansion of therapeutic interventions and possibilities for schizophrenia, which culminated in a type of redefinition of the disease prognosis. In spite of the recognized heterogeneity in regard to the course of every mental pathology, schizophrenia has been linked to a history of failure, incapacity and deterioration in the classic psychiatric literature (Clarke & O'Callaghan, 2003). The prognosis of the disease used to be extremely negative: recovery would be possible in just a few cases; treatment would offer extremely strict possibilities of effective improvement of the patient's living conditions, and, for the professionals involved, treating these cases would actually mean to follow up the patient's deterioration and chronification.

According to McGorry et al (1996), the massive financial investment of the 1970's and 1980's, and the consequent increase in the number of researches about schizophrenia propelled a change of perception in relation to the course of the disease. Said course would no longer be reduced to an inevitable chronification, and new therapeutic possibilities began to be elaborated. With the enhancement of psychoactive drugs and the appearance of the second generation of antipsychotic drugs, there is the emergence of a special interest in the early stages of the disease and in the possibilities of intervention that would change its course, enabling a more optimistic expectation about the reduction of morbidity and the improvement of the patients' quality of life.

In this context, studies on the first psychotic episode are developed, in addition to the formulation of early intervention strategies, according to which the clinical care in initial moments would be effective and would promote more positive prognoses of recovery of the disease. The intention of the first services was to provide psychiatric assistance to the initial cases, and to reduce the damage caused by the iatrogenesis resulting from the longtime of waiting and suffering before the first attempt to search for specialized assistance. In addition, the admission of young patients to conventional treatment programs used to be traumatic and stigmatizing, as it was commonly based on coercive practices and overdose of antipsychotic drugs. In this sense, an important objective, whether clinical or regarding public health planning would be the development of specific services to assist the first pathological experience.

The discussion about the period of untreated psychosis stands out among all proposals of early intervention. Literary review studies suggest that the duration of untreated psychosis, that is, the time between the outbreak of the first psychotic episode and the beginning of the treatment is a potentially modifying factor of the disease, and the understanding of it can enable therapeutic strategies and innovative public health initiatives (Lieberman & Fenton, 2000; Clarke & O'Callaghan, 2003; Hafner & Mauer, 2006). Although quite variable, the average time of untreated psychosis is around a year, very long if compared to other pathologies. In this period, the individual would be exposed to psychosocial damages and to the beginning of a path of difficulties with aggravation tendencies.

From the need to assist these young patients and to reduce the long period of untreated psychosis, investigation services and clinical protocols started to be developed. The initial concern motivating the creation of the services resided in the quality and the temporal resolution of the treatment offered, and the ultimate objective was to offer effective and quick forms of care, adequate to the specific characteristics of the first psychotic episode. This is the motivation declared by the researcher and pioneer in early psychosis services and investigations, the Australian psychiatrist Patrick McGorry. In article dated from 1996, McGorry et al report the creation of the Early Psychosis Prevention and Intervention Centre (EPPIC), a pioneer clinical service developed in Melbourne, Australia, primarily intended to perform the secondary prevention of psychotic disorders. Recognizing the psychiatry inability for carrying out the primary prevention, the author defends that efforts must be concentrated on the early detection and intervention for adolescents and young adults experiencing the first psychotic break, or that are about to experience it. Thus, the pioneer proposal implemented in Australia and presented in the article suggests that: "a realistic secondary preventive approach would involve strategies that first reduce the duration of untreated psychosis and second optimize the management the disorder in the first year after detection." (McGorry et al, 1996, p.306).

The EPPIC begins operating in 1992 with two complementary clinical objectives: first, to identify patients in the first stages of psychosis break; second, to offer intensive treatment, specifically formulated to meet the needs of this stage during the two years after the first break. It was a community-based clinical service that included educative activities aiming to sensitize the community about the characteristics of the psychosis in its early state, and a significant concern with the reduction of the stigma and the prejudice that surround psychiatric services and their patients. The clinical activities were developed under the supervision of a clinical professional, and consisted of individual and group activities, cognitive-behavioral therapy adapted to early psychosis, and medication with low doses of neuroleptics.

Just as other services later implemented in the United Kingdom, USA and Asia, the EPPIC linked the offering of clinical actions to a research protocol in order to systematize the interventions carried out and to assess the benefits achieved. From the gathering of research information and exchange of experiences between the first services, an international research network was created, and a consensus about the best practices was reached, culminating in the publishing of clinical guidelines for early intervention (IEPA, 2005). Currently, early intervention in psychosis is a therapeutic approach available in many countries of the Americas, Europe and Asia[3], whose main treatment strategy consists on the combination of reduced doses of drugs, and cognitive-behavioral therapy adapted to early intervention (Bird, Premkumar, Kendall, Whittington, Mitchell, & Kuipers, 2010; Marshall & Rathbone, 2011; Vyas & Gogtay, 2012).

CONTROVERSIES ABOUT EARLY INTERVENTION: THE NOTION OF THE AT RISK MENTAL STATE

A range of challenges regarding the clinical care offered in services of early detection continues to be discussed: starting with the efficacy of the drugs in this phase and the balance between the benefits in the reduction of the symptoms and the impact of side effects (Vyas & Gogtay, 2012), going through discussions about the best psychotherapeutic strategies, such as the cognitive-behavioral therapy and the family therapy (Bird et al, 2010), coming to the questioning about the long-term maintenance of the positive effects obtained in the services of early intervention, with the decrease in hospitalization rates and in the number of new aggravation episodes of the symptoms (Bird et al, 2010).

However, if the first EPPIC-type services had as main objective the immediate and effective offering of mental healthcare to patients

[3] The IEPA website lists the early intervention services available worldwide, including two Brazilian services: the GIPSI from University of Brasília (www.gipsi.org.br), and the ASAS from University of São Paulo Clinics Hospital (www.ipqhc.org.br). See: www.iepa.org.au.

experiencing the first psychotic symptoms, the clinical guidelines published by the IEPA proposed a step further. According to the International clinical practice guidelines for early psychosis (IEPA, 2005), the general objectives of the early intervention are to minimize iatrogenesis, to promote better ways out of the crisis and to increase the quality of life of patients primarily through antipsychotic medication, cognitive therapy and educational support. It is a program developed within the clinical context, linked to research protocols, intended to promote more efficient individual treatments, to minimize the psychosocial impact on the life of the young patient, and, if possible, to delay or even prevent the outbreak of the first psychotic episode and the installation of mental disorder.

The interventions aim at three different targets: a) the pre-psychosis phase, long and characterized by prodromal symptoms; b) the period of untreated psychosis that, if long, becomes a risk factor for the chronification of the disease; and c) the first episode and the years following the diagnosis, a critical period for intervention. The characteristics and consequences of the early intervention differ between that directed to the first group of individuals and those directed to the second and third groups. In the cases of individuals experiencing a period of untreated psychosis and the first psychotic break, the intention is to offer treatment to young subjects living a psychic disorganization and loss of functionality, before the mental disease is definitively installed and provokes incapacity. As said above, many are the clinical challenges faced in the preparation and assessment of the best therapeutic strategies to be provided to these young individuals, but current researches indicate that this type of intervention is capable of producing better results than those achieved in unspecific mental health services. Moreover, the proposal seems to be able to bring about a reasonable consensus within the scientific community, since it constitutes more of an enhancement and refinement of services, strategies and clinical options established, in agreement with the proposal of the first services of early detection.

In the case in which the subjects are identified as being in the at risk mental state or, according to clinical guidelines, in the pre-psychosis phase, intervention is directed to young people who actually do not present the disease, but would be at risk of developing it. These adolescents and young adults would not be identified as schizophrenic, according to current diagnostic criteria, but would be living behavioral and cognitive changes that could be linked to experiences that characterize the psychotic break, such as changes in their way of thinking, abnormal perceptions, speech disorganization, social withdrawal and poor academic performance. Usually, behavioral and cognitive changes are continuous, but of low intensity, or acute, lasting a short period of time, reason why the individuals would not come to receive the diagnosis of schizophrenia, according to the DSM-IV.

Therefore, the concept of at risk mental state refers to a set of symptoms or behaviors that signalize the possibility of the disease outbreak, but are not a guarantee of it. In this context, the substitution of the term prodromal for the terms at risk mental state or ultra-high risk would have as advantage the indication that the transition to psychosis is not inevitable, and would facilitate the attention to false positive cases. For some researchers, this symptomatic but pre-psychotic stage would be the earliest moment to which a prevented intervention could be conceived (McGorry, Killackey & Yung, 2008).

An evident challenge is inherent to the proposals of intervention to individuals in the pre-psychosis phase or in the at risk mental state: the distinction between those who need intervention and those who would not benefit from it. Several clinical researches with a small number of participant individuals started to be developed aiming at the at risk mental state, and one of the main objectives consisted exactly on the delimitation of the at risk mental state itself and on its correct identification. After all, what does the psychosis at risk mental state characterize? What are the safest criteria for its identification? How to establish exclusion and inclusion factors in clinical protocols in order to delimitate more precisely this category?

The precursor McGorry and his Australian research group came up with a definition widely used in clinical investigations, which ended up constituting a reference in the field, although other researchers might criticize it. The model defines three groups of criteria for the identification of the at risk mental state, and at

least one of them must occur: a) Attenuated Psychotic Symptoms Group: presence of at least one positive attenuated psychotic symptom during the previous year; b) Brief limited intermittent psychotic symptoms group: presence of evident but momentary psychotic episodes that ceased spontaneously in a week; c) Trait and state risk factors group: presence of genetic risk – first-degree relative of the psychotic disorder or schizotypal personality disorder, and occurrence of the patient's functional deterioration. Besides fitting into, at least, one of the criteria above, the individuals must be aged between 14 and 30 years old, and not having experienced any previous psychotic episode (McGorry et al, 2001; McGorry et al, 2003; McGorry, Killakey & Yung, 2008).

According to data presented in 2003, the rate of transition to psychosis in the group identified in accordance with the criteria above stood around 40% in twelve months of follow-up (McGorry et al, 2003). That is, among the participants of the first clinical studies, identified as experiencing the at risk mental state, around 40% developed a picture of psychotic break. To said authors, the high rate of conversion to psychosis indicated that the criteria for the identification of the at risk mental state had a considerable acuity in the detection of young subjects at extreme risk of developing a psychotic disorder within a short period. Since the publishing of the first clinical studies with patients in the at risk mental state, a range of new researches have been conducted, assessment instruments have been developed, and debates on the challenges, benefits and damages of the intervention in this little defined psychopathological period have been mobilizing researchers dedicated to the study of the early intervention.

Subsequent researches continued seeking to investigate and to refine the definition of at risk mental state, to determine more precisely the rates of conversion to psychosis – which could guarantee the safety of the identification criteria of at risk mental state, and to prevent the appearance of false positive cases –, and to test the possibilities of treatment or of intervention to be offered to this population. While the scientific evidences longed for by researchers about the characteristics and the best interventions to be provided to these young individuals experiencing the at risk mental state are considered preliminary, the recommendations are, according to McGorry (2008), conservative: young subjects in the at risk mental state who seek for specialized assistance, or who are sent by people that are close to them, must be provided with continuous and specialized follow-up based on psychosocial interventions, and, when necessary, with medication for anxiety and depression symptoms, avoiding the use of antipsychotic drugs (IEPA, 2005; McGorry et al, 2008).

FROM A CLINICAL STRATEGY TO THE PROPOSAL OF A DIAGNOSTIC CATEGORY: THE AT RISK MENTAL STATE IN THE DSM-5

With the increase in the number of researches about the at risk mental state, and the preparation of a new edition of the DSM coming up, a controversial proposal was presented by the workgroup dedicated to psychoses in the review of the manual: the inclusion of a new diagnostic category, the *Psychosis risk syndrome*, in the version to be published in 2013. In 2010, the group led by William Carpenter presented the proposal of inclusion of the category on the website destined to the disclosure of and public consultation to the review of the manual. In face of the innumerous criticisms received after the first presentation, the group renamed the category and reintroduced it as *Attenuated psychotic symptoms syndrome*, which was subjected to a new round of comments in the public consultation.

Based on studies conducted over the last fifteen years about the at risk mental state, the proposal of reformulation of a new category that identified the pre-psychosis period had as one of its main defenders Patrick McGorry, the Australian researcher and precursor of studies on early intervention. Although they recognize the dangers and challenges implied in the construction of the new diagnostic category, McGorry and Carpenter defended its clinical usefulness, which would be not only necessary, but also fundamental to support initiatives of change in the psychiatric practice towards an anticipatory intervention in psychotic disorders, stimulating the education and practice of clinical professionals, and favoring the organization of scientific researches (Carpenter, 2009; McGorry, 2010). According to Carpenter: the [psychiatric]

field will be challenged to manage this new category prudently. But, without the category, a framework for early detection and intervention is lost, and the opportunity to develop evidence-based treatment will be minimized. (2009, p.842).

Woods, Walsh and McGlashan (2010) gathered, in an article, arguments in favor of the inclusion of the new category, reviewing the main published evidences that could support it. According to the article, the main arguments that sustain and justify the construction of the *Attenuated psychotic symptoms syndrome* category are: the patients are presenting psychopathological changes; the patients are at a high risk of worsening; none of the diagnostic categories of the DSM-IV is capable of accurately capturing the current disease or the future risk of these patients; the diagnosis has been established with reliability and validity in the context of the research; and its inclusion into the DSM-5 would help promote the necessary treatment and preventive researches to allow for the provision of a care that benefits patients and their families.

For the supporters of the category, the assistance to patients at risk and the construction of early interventions in psychosis, both prior to the possibility of performing a stable diagnosis in accordance with the DSM-IV, would not possess orientation criteria and parameters. To McGorry (2010), the current diagnostic definitions do not favor the comprehension of the psychopathology as a complex neurodevelopmental process, characterized by a gradual and continuous evolution, and marked by different stages. In this way, there would be a need for parameters that allowed for the distinction of the different stages and oriented the intervention in the initial moments of the disease, in which behaviors distance more subtly from the normality criteria, and a diagnosis becomes harder.

If the researches dedicated to the definition of the at risk mental state already generated controversies and ethical debates, the proposal of formalizing the alleged period of risk for psychosis as a diagnostic category has produced a lot of discussion and divergence. The dimensions of the discussion have probably been increased by the possibility of public consultation and, especially, by the involvement of outstanding figures in psychiatry in the intense debate held on the internet. In this context, Allen Frances was one of the main critics of the inclusion of the new category, publishing several articles contrary to the proposal on his blog 'DSM-5 in Distress'.

In addition to the debate held on the internet, many articles were published reflecting about the risks and benefits that the new diagnostic category could bring to the attention in mental health aimed at adolescents and young adults (Corcoran, First, & Cornblatt, 2010; McGorry, 2010; Yung, Nelson, Thompson & Wood, 2010; Woods et al, 2010). Among the risks discussed, there is a special highlight to false positives and the lack of safe information about the best options of treatment or intervention to be offered to this population.

False positive cases refer to the possibility of diagnosing individuals that would never come to develop a psychotic disorder. In this sense, it is important to question whether the definition criteria of the at risk mental state really discriminates a high-risk group of patients, which is not simple, considering that such behaviors should be identified in adolescents and young adults, who usually go through periods of changes and behavioral experimentation. Furthermore, some articles mention recent researches suggesting that the presence of attenuated psychotic symptoms is more frequent among the general population than previously assumed (Yung et al, 2010), and question the possibility that a so refined diagnostic can be easily and safely disseminated in less specialized contexts of attention, for instance, among professionals of the primary care (Corcoran et al, 2010).

Because the precise definition of the individuals that would be correctly diagnosed is not simple, other important questions emerge regarding the consequences of the application of the diagnostic category. The stigma to which adolescents and youths would be subjected to stands out as a factor to consider in the reflection about the damages caused by the possibility of early treatment, since the patients would enter the universe of the psychiatric services, even though they would not use the antipsychotic medication before such procedures are clearly necessary (Corcoran et al, 2010; Yung et al, 2010).

Besides the stigma, the undesired consequences of the intervention itself to be

offered also stand out as relevant questions in the discussion. Concerning the safety and efficacy of the strategies available, even the supporters of the early intervention recognize that the early diagnosis becomes worthy of criticism when there is no effective treatment available, or when the treatment, if applied early, may result in more damages than benefits to the patient (McGorry, 2005; 2010). Therefore, questions about the statute and usefulness of the new conceptualization quickly emerge: in face of the social and psychological cost that may result from the stigma of being diagnosed as a subject with mental disorder, would it be legitimate to diagnose and treat potentially psychotic patients? Are the possibilities of intervention currently available effective to this type of patient, bringing real benefits? Are the interventions effectively transforming and preventive that is, do they prevent the development and installation of mental disorder, or retard the appearance and attenuate its impact?

When recognizing that the risks and benefits of the intervention strategies have not been sufficiently clarified yet, some authors of the field point to the need for controlled experiments that can prove the efficacy of the treatment, and consider that the inclusion of the category into the DSM-5 would constitute a premature decision. To Allen Frances, such decision would not only be premature, but "*the worst DSM-5 proposal*", as published in his blog (Frances, 2012a). According to the author, in a post published on January 5, 2012, the inclusion of the category caused divergence even inside the workgroup dedicated to the review of psychotic disorders, in such a way that McGorry himself, one of its main defenders in the beginning of the process, had changed his mind and no longer supported the *Attenuated psychotic symptoms syndrome.*

Later gathered in the book *Saving Normal* (2013), the arguments presented on the blog by Frances draw attention to the disastrous consequences announced in the proposals of the DSM-5: the medication of normal people, the inflation of the number of psychiatric categories, and the encouragement to the inappropriate use of psychotropic drugs. Regarding the category of risk for psychosis, Frances summarizes the debate by listing five arguments contrary to the inclusion: 1) the elevated number of people that would receive the diagnosis without coming to develop any disorder in the future, the so-called false positive cases; 2) the inexistence of proven forms of preventing psychosis, even to those subjects considered at risk; 3) the side effects that could result from the unnecessary use of antipsychotic drugs: obesity, diabetes, heart disease, and consequent decrease in life expectancy; 4) the stigma and concern provoked by the assumption that psychosis is imminent; 5) the mistaken approximation between being at risk and having the disease (Frances, 2013).

Finally, after a long debate and a torrent of criticisms, on April 27, 2012, it is announced that the category will be removed from the last version of the manual to be published for public consultation, no longer constituting an alternative to the version of the DSM to be published in 2013. According to Carpenter, leader of the workgroup responsible for such decision, the results found in the field trials were not statistically significant, reason why the category would be excluded from the manual. In the coverage of the category, published on the website *Nature*, Carpenter regrets the exclusion, defends the validity of the category and states that, although he respects the collective decision, "if I had been there, I would have tried hard to plug that reliability gap by capturing more data" (Nature/News, 2012). To Frances, "The world is a safer place now that *'Psychosis Risk'* will not be in DSM 5" (Frances, 2012b).

FINAL CONSIDERATIONS

The attempt to include in the DSM-5 a diagnostic category intended to identify the at risk mental state shows that the theme has acquired some stability in the psychiatric field, but, as we have seen, it has also generated criticisms and oppositions. The discussions held through academic publications, websites, blogs and other virtual spaces exemplify the processes of social contestation and negotiation of the medical categories to which Rosenberg (2006) refers. As the author shows, conflicts about the medical, social, epistemic or ontological statute of mental disorders, just as discussions on etiology, diagnosis and therapy, have been permanent in the history of psychiatry over the last 150 years.

In the last decades, the preponderance of the reductionist and mechanicist model of the

neuroscientific project has brought the hope of reduction of the illegitimacy of the diagnostic categories. To many people, the biological psychiatry and the neuroscientific knowledge linked to it would be capable of, finally, offering the somatic support that have been absent in the psychosocial descriptions of mental diseases, and, with that, guaranteeing more legitimacy to the categories. However, as Rosenberg (2006) observes, at the same time the genetic, molecular and neurochemical explanations about the mental disease starts to dominate the field of the contemporary psychiatry, the criticisms about the contingency and arbitrariness of the classifications increase.

The construction process of the mental disease as a medical entity has never been immune to debate or uncertainty, and the last few decades saw criticisms growing stronger. From the antipsychiatry movement, going through feminist studies and recent sociological and anthropological criticisms, many are the origins of the contestation of the legitimacy of the psychiatric classification, and intense is the process that reports its ambiguities. To the author, since the last third of the 20th century, the boundaries of the diagnostic categories have been extending and, simultaneously, suffering criticisms, being subjected to debates and having their statute as medical entities objected.

The proposition of the *Attenuated psychotic symptoms syndrome* exemplifies, in the current context, the processes to which Rosenberg refers. Concerning the expansion, it is possible to observe that said category would imply an increase in the number of individuals subjected to psychiatric investigation and intervention. As we have seen, the category has been developed to identify adolescents and young adults that are experiencing the risk of a future psychosis outbreak. If such definition starts to be used in a systematic manner, the number of adolescents and young adults identified as being in the at risk mental state will certainly be significantly superior to that of those who effectively receive the diagnosis of schizophrenia or who happen to receive it in the course of their lives.

Probably, the potential for the expansion of the psychiatric intervention is the most visible consequence of the application of the risk logic to the field of mental phenomena. Nevertheless, the specific characteristics of the notion of at risk mental state bring new challenges and specificities to the process of psychiatric classification and action. By definition, at risk mental state refers to a border experience that is not reduced or equivalent to neither the normality state we relate to health nor to the pathological states we designate as mental disorders. If the recognition of such states can emerge from a refinement of clinical strategies, as we have seen, their systematization depends on the construction of objective, measurable parameters, little subject to variation, capable of generating enough consensus within the scientific community in order to include them in the current classification schemes.

The challenge in the preparation of a diagnostic criterion that, by definition, is found in the intermediate and fluid space between the normality and the mental pathology became evident during the discussion that preceded the publishing of the DSM-5. To beyond the classificatory dimension itself, with the rise of the risk logic in psychiatry, we observe a tendency to vagueness in the boundaries between normality and pathology. Traditionally defined by the diagnostic categories, these boundaries become increasingly more imprecise and, consequently, more subject to contestation when risk starts to be used as a criterion for the construction of diagnostic categories or as a foundation for the development of clinical interventions.

It is worth questioning which benefits the appropriation of the risk logic would bring to the field of the mental healthcare. Although the *Attenuated psychotic symptoms syndrome* have been removed from the list of diagnostic categories of the DSM-5, the notion of at risk mental state continues to be investigated and used in a preliminary manner – linked to research protocols – in mental health clinical services to adolescents and young adults. However, along with the definition of inclusion criteria in the category, the type of intervention to be offered to patients is still being discussed as well.

As researchers supporters of the early intervention affirm, the at risk mental state represents an intermediate state, which begins to be followed up by specialists, and, therefore, no longer summarizes the health state, but does not necessarily implies the development of the disorder, and it is not equivalent to the diagnosis of the disease. If the interventions constructed in the context of the services of early detection, in a first moment, represented the refinement of clinical instruments, especially for patients living

the first episode, for risk cases, it is not known what to offer exactly; thus, an intervention that can change the alleged vulnerability of adolescents and young adults remains undefined.

In the clinical dimension, the discussion on the early intervention directed to the first break, with special attention to the period of untreated psychosis, may represent the construction of care instruments and strategies useful in the assistance to the psychopathology of adolescents and young adults. At the same time, the formalization of the diagnostic category risk psychosis points more to an intention of applying the risk thinking to the psychiatric field, and of carrying out preventive actions whose efficacy and safety are not known. The questioning about the boundaries between normality and pathology is not only beneficial, but also essential to the construction of care practices that are more sensitive to psychic suffering. However, as suggested in the analyses by Castel (1987, 1991), Castiel (1999) and Dumit (2012), among others, this has not been the most frequent destination of the transformations made in the health field from the valuation of the notion of risk.

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