As the American Psychiatric Association committees begin formal work on DSM-V, we welcome brief editorials on issues that should be considered in its formulation.

Issues for DSM-V: Clinical Staging: A Heuristic Pathway to Valid Nosology and Safer, More Effective Treatment in Psychiatry

Clinical staging is a proven strategy whose value is clear in the treatment of malignancies and many other medical conditions in which the quality of life and survival rely on the earliest possible delivery of effective interventions, yet it has not been explicitly endorsed in psychiatry (1–4). Clinical staging differs from conventional diagnostic practice in that it defines the progression of disease in time and where a person lies along this continuum of the course of illness. It enables the clinician to select treatments relevant to earlier stages because such interventions may be more effective and less harmful than treatments delivered later in the illness course (5). Although staging links treatment selection and prediction, its role in the former is more crucial than in the latter, particularly since early successful treatment may change the prognosis and thus prevent progression to subsequent stages.

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A disorder that is potentially severe and may progress if untreated is likely to be most appropriate for staging. Treatment and particularly early treatment should also demonstrably increase the chances of cure or at least of reducing mortality and disability. This could include many or even most psychiatric disorders.

Defining discrete stages according to progression of disease creates a prevention-oriented framework for understanding pathogenesis and evaluation of interventions. The key outcomes are prevention of progression to more advanced stages or regression to an earlier stage. This requires an accurate understanding of the broad social, biological, and personal risk and protective factors that influence movement across stages. We need to know the relative potency of such risk factors and whether they are malleable by current interventions. The burgeoning arena of gene-environment interactions (6) is directly relevant; these environmental variables such as substance abuse, psychosocial stressors, cognitive style, medication adherence, and social isolation may interact with genetic and other biological risk factors at a particular time in the pathogenesis of the illness. A clinical staging model, which maps the relationship of biological change to stage of illness, may help to validate or redefine clinical boundaries, distinguish true pathophysiology from epiphenomena or sequelae, and enable much existing data to be better understood.

In the clinical arena, we are already able to see that improved outcomes based on a staging approach are more readily achievable (7–10). For schizophrenia and related psychotic disorders, the progression from prodromal symptoms to the first psychotic episode to chronic psychosis and cognitive and social deterioration is by no means inevitable. Many people who reach one stage may not progress to the next and may even remit from their illness entirely. Although such spontaneous remissions were well known even before neuroleptic treatment became available, we are now in a position to assess if specific interventions, including medication and psychosocial interventions,

increase the number of persons who are saved from the progression toward chronic psychosis and deterioration. The specification of the characteristics of specific stages of schizophrenia in DSM-V would provide a framework for the comparison of results from preventive efforts across many different centers and may ultimately have implications for other psychiatric disorders.

References

1. Fava GA, Kellner R: Staging: a neglected dimension in psychiatric classification. Acta Psychiatr Scand 1993; 87:225–230
2. McGorry P: A treatment-relevant classification of psychotic disorders. Aust NZ J Psychiatry 1995; 29:555–584
3. McGorry PD: Early intervention in psychotic disorders: beyond debate to solving problems. Br J Psychiatry 2005; 48(suppl):s108–s110
4. McGorry PD, Hickie IB, Yung AR, Pantelis C, Jackson HJ: Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier, safer and more effective interventions. Aust NZ J Psychiatry 2006; 40:616–622
5. Sackett DL, Haynes RB, Guyatt GH, Tugwell P: Clinical Epidemiology: A Basic Science for Clinical Medicine. London, Little, Brown, 1991
6. Caspi A, Moffitt TE: Gene-environment interactions in psychiatry: joining forces with neuroscience. Nat Rev Neurosci 2006; 7:583–590
7. Craig TK, Garety P, Power P, Rahaman N, Colbert S, Fornells-Ambrojo M, Dunn G: The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. BMJ 2004; 329:1067
8. Petersen L, Jeppesen P, Thorup A, Abel MB, Ohlenschlaeger J, Christensen TO, Krarup G, Jorgensen P, Nordentoft M: A randomised multicentre trial of integrated versus standard treatment for patients with a first episode of psychotic illness. BMJ 2005; 331:602
9. Morrison AP, French P, Walford L, Lewis SW, Kilcommons A, Green J, Parker S, Bentall RP: Cognitive therapy for the prevention of psychosis in people at ultra-high risk: randomised controlled trial. Br J Psychiatry 2004; 185:291–297
10. McGorry PD, Nordentoft M, Simonsen E (eds): Introduction to "early psychosis: a bridge to the future." Br J Psychiatry 2005; 187(suppl):s1–s3

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Editorials discussing other DSM-V issues can be submitted to the Journal *at http://mc.manuscriptcentral.com/appi-ajp. Submissions should not exceed 500 words.*