The Risk-Benefit Ratio of the Proposed DSM-5 Attenuated Psychosis Syndrome

To the Editor: We commend Dr. Weiser's editorial on early intervention in patients at risk for schizophrenia in the August 2011 issue of the *Journal* (1) and in particular his conclusion that current evidence does not support the practice of routinely offering such patients clinical treatment with antipsychotic medication. However, we must take issue with the hypothetical clinical case patient who displays the attenuated positive symptoms used to identify risk. Because the attenuated positive symptoms cause the patient no distress and his sole reason for seeking treatment is unrelated to the specific symptoms, his risk is presumably low.

As Dr. Weiser notes, such a patient might meet research criteria for ultra high risk (2) or a psychosis risk syndrome (3) if the nondistressing attenuated positive symptoms were rated as sufficiently severe to pass threshold, but this hypothetical case would *not* meet the proposed DSM-5 criteria for attenuated psychosis syndrome. The criteria currently being tested in field trials do not permit such presumably low-risk patients to receive the diagnosis because criterion D requires that the attenuated positive symptoms themselves must be "sufficiently distressing and disabling to the patient and/or parent/guardian to lead them to seek help" (4, 5). The field trials should help determine whether these criteria can be applied with reliability in the clinical setting.

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Response to Woods and McGlashan Letter

To the Editor: I thank Drs. Woods and McGlashan for reading and commenting on the editorial. Their letter examines the hypothetical case of a young man with attenuated psychotic symptoms who has "an emotional crisis when his girlfriend leaves him." Their understanding is that the symptoms "cause the patient no distress" and hence would not meet the proposed DSM-5 criteria for attenuated psychosis syndrome.

In the editorial, our hypothetical patient "might be upset, have difficulty sleeping at night, have difficulties concentrating, have decreased functioning at school or at work, and have more attenuated psychotic symptoms. If this person goes to a psychiatrist presenting with this clinical picture, he might very well meet criteria for the prodromal phase."

This is clearly a description of a distressed person who seeks the help of a psychiatrist. Since criterion D of the proposed DSM-5 criteria for attenuated psychotic syndrome requires that the attenuated positive symptoms themselves must be "sufficiently distressing and disabling to the patient and/or parent/guardian to lead them to seek help," our patient would meet the criteria.

I join Drs. Woods and McGlashan in their hope that the DSM-5 field trials will help determine whether these criteria can be applied with reliability in the clinical setting.

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Neurocognitive Response to Deep Brain Stimulation for Obsessive-Compulsive Disorder

To the Editor: When obsessive-compulsive disorder (OCD) symptoms are severe and refractory to both cognitive-behavioral therapy (CBT) and medication, deep brain stimulation (DBS) may be of value (1). Although OCD research has examined the effects of DBS on cognition (2), few studies have used translational computerized paradigms capable of fractionating dissociable aspects of cognition and their neural substrates. Neurocognitive assessments have the potential to help elucidate the underlying mechanisms of action of DBS in OCD and the optimal brain target.

Case Report

"Mr. T" is a 30-year-old man with a 5-year history of OCD with primary contamination obsessions and washing compulsions. He had stopped socializing, had dropped out of school, and was unemployed because of his OCD. Past adequate trials of all serotonin reuptake inhibitors, both as monotherapy and with multiple augmentation strategies, and 20 weeks of CBT using exposure response prevention provided only limited benefits.

After ethical review board approval, Mr. T underwent bilateral implantation of electrodes targeting the nucleus accumbens. At the time of surgery, his Yale-Brown Obsessive Compulsive Scale score was 32 while taking the following medications: clomipramine, 250 mg/day; ziprasidone, 120 mg/day; and clonazepam, 1 mg t.i.d. His medication dosages were unchanged before and after the cognitive testing.

We performed cognitive assessments at baseline (prestimulation) and again 8 months after DBS began. Tasks from the Cambridge Neuropsychological Test Automated Battery included the stop-signal test (assessing ability to suppress prepotent motor responses), the intradimensional/extradimensional set shift task (examining rule