

## VI. Special Issues

### The Prodromal Phase of Schizophrenia

The prodromal phase of the illness is defined as the period of nonspecific behavioural changes and symptoms that occur before the onset of clearly identifiable psychotic symptoms. The prodromal phase is usually preceded by a premorbid phase during which there may be general deficits in social and academic functioning. However, not all behaviours and symptoms regarded as prodromal lead to psychosis, and hence the utility of this concept is limited. Nonpsychotic prodromal symptoms such as depression, anxiety, and social withdrawal are relatively common phenomena seen in different psychiatric disorders and in the general population, especially among adolescents. Hence, such symptoms have limited specificity for predicting future psychosis. However, in patients with established illness, these symptoms may be useful as monitoring warning signs for an impending relapse (238,278–280).

Recently, there has been a significant improvement in more reliably defining the period immediately preceding the full onset of psychosis. This has been termed the “ultra high-risk

mental state” and is defined by either onset of attenuated psychotic symptoms not reaching threshold for psychosis or brief intermittent psychotic symptoms lasting less than 7 days or a combination of a trait (positive family history of psychosis in first-degree relatives) and a significant decline in global functioning in the previous year. According to these criteria, the ultra high-risk group has shown transition to psychosis at the rate of around 30% to 40% in the first year (22,281,282).

While no definitive treatment can be recommended at this time for individuals meeting criteria for ultra high risk prior to the full onset of psychosis, there is preliminary evidence that low-dosage risperidone (283) and medium-dosage olanzapine (284–286) may reduce the risk of conversion to psychosis, reduce symptoms, and improve functioning. Similar reduced conversion to psychosis has been reported recently with the use of CBT (287). However, well-designed investigations of nonpharmacologic therapies and pharmacologic interventions other than antipsychotic drugs have not yet been carried out.

**Table 9 Recommendations**

Recommendations	Evidence	Evidence level
Patients who meet criteria for “ultra high-risk mental state” for psychosis should be offered monitoring for at least 1 to 2 years; if clinically indicated, they may be offered supportive therapy and symptomatic treatment for emerging psychotic symptoms, depression, or anxiety.	Patients who meet criteria for ultra high-risk mental state for risk of psychosis show a 30% to 40% rate of conversion to psychosis within 1 year of observation.	B
If they convert to psychosis, treatment for psychosis should begin immediately; this will avoid any delay in treatment and may portend better engagement and improved outcome.	Delay in treatment of psychosis is related to poor outcome.	B

