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rate; stigma; absence of data on reliability and validity of high-risk criteria in ordinary practice settings; and the absence of evidence-based interventions. These four concerns are mitigated to some extent by the following considerations.

Criteria Under Consideration

The currently proposed criteria for the psychosis risk syndrome include attenuated psychotic symptoms, distress, dysfunction, and importantly, help-seeking. These symptomatic, help-seeking individuals will receive some diagnosis. The issue is whether having the option of assigning the psychosis risk syndrome is more valid and beneficial than a diagnosis that would otherwise be selected. There also is a diagnostic hierarchy whereby the risk syndrome class is not used if the person meets criteria for another relevant disorder. Keep in mind that another criterion for psychosis risk syndrome would be not meeting criteria for another DSM diagnosis.

It is shameful that a psychiatric diagnosis is stigmatizing, but reality requires attention to this issue. Young people who become suspicious, withdrawn, have peculiar experiences, and manifest distress and/or functional impairment will experience stigma even without coming for clinical services. Receiving psychiatric care of any kind might be stigmatizing. Whether the stigma is greater for psychosis risk syndrome is not known.

Validity data have been established in research settings (see Woods et al., [Schizophr. Bull. 2009;35:894-908]). The issue of reliability in ordinary settings is to be determined in field trials. Without adequate reliability, the currently proposed risk syndrome will not be recommended for inclusion as a new class.

The Politics of Early Intervention

The question of prevention/therapeutic intervention is critical to the politics of this issue. The DSM is not a therapeutic manual, and valid disorders should be classified regardless of treatment knowledge. But as a practical matter, in the absence of documented treatment efficacy, opposition to moving forward with the risk syndrome probably will continue. At the moment, the recommended approach (see "Early Intervention in Psychosis: WPA Education Committee's Recommended Roles for the Psychiatrist," http://www.wpanet.org/v1/education/pdf-ed-prog/early-psychosis.pdf) is working with the individual and family to diminish stress, resolve issues of conflict, and monitor for emerging psychosis. There is not much objection to this approach. The concern centers on the prospect of inappropriate and excessive use of antipsychotic medication. This concern is valid, but the question remains as to whether the inclusion of a risk syndrome category in the DSM would increase or decrease the unwise prescription of antipsychotic drugs. Currently, most of the young people being treated with these drugs do not have a psychotic diagnosis.

My personal view at the moment is that we should move forward with the risk syndrome category for the DSM-5, with minor neurocognitive disorders and psychosis risk syndrome being lead candidates for inclusion. This view is, however, a point of ongoing debate within our work group, as well as outside experts.

For all of us, I think the deciding issue is the risk/benefit calculation rather than the validity issue. My emphasis is placed on the potential good of early intervention for those persons fated for a psychotic disorder, and who are seeking help, either personally or through concerned family members.

My concern for the false-positive cases is real but muted by the realization that these persons are likely to receive some other incorrect diagnosis and treatment, hence the uncertainty as to whether more harm than good will be done. Antipsychotic drug treatment is not founded on evidence for either the true-positive or false-positive cases, and is of substantial concern.

So, on what factors will the decision in 2012 be based? Reliability, feasibility, and clinical utility results from DSM-5 field trials will play a key role. Beyond that, current opinions might stay in place until a preventive or therapeutic option is compelling. In this regard, a recent report (Arch. Gen. Psychiatry 2010;67:146-54) is remarkable. High-risk subjects were identified and randomly assigned to receive placebo or 3-omega fatty acids for 12 weeks. Transition to psychosis, and symptom and functional status were evaluated over the following 40 weeks.

Investigators found that a psychotic disorder emerged in 27.5% of the placebo group, but only 4.9% of the experimental therapeutic group. Symptom status and functional outcomes also were statistically superior for the 3-omega fatty acid cohort. The fact that 12 weeks of treatment provided protection for the subsequent 40 weeks raises the possibility of a critical point for preventive intervention. If these results are replicated in the now ongoing multicenter study, it will be surprising if opinion does not move in favor of a risk syndrome category for the DSM-5—with psychosis risk syndrome as a lead candidate for inclusion. ■

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COMMENTARY

Don't Let ADHD Crush Children's Self-Esteem

Picture a child with attention-deficit/hyperactivity disorder (ADHD) in school, doing what kids with ADHD do: fidgeting, blurting out answers, jumping out of the chair, or zoning out because of some distraction during the science lesson.

It's not too much of a stretch to assume that such a child might receive a negative or corrective comment from the teacher, say, three times an hour "Pay attention!" "Sit still!" "Get back on task!" Let's say the child is in class 6 hours a day for 180 days of school each year. That's more than 3,200 nonpositive comments directed at a child each year and does not include a single annoyed comment from a coach or an angry scolding from a parent.

BY MICHAEL S. JELLINEK, M.D.

In school alone, a child with ADHD could receive 20,000 corrective or negative comments by the time he or she is age 10.

Medication does help many of these children, but even if it reduces behaviors that elicit negative comments by 50% or 75%, the child still is left with a heavy burden of criticism and a message that a lot of what he's about is not OK.

Even medication carries its own challenge to self-esteem if family members question its benefits, or siblings taunt the child for taking a pill.

Learning disabilities are common comorbidities in children with ADHD, so they might feel "stupid" and receive lackluster grades even if they're working harder than their peers. They might have difficulty reading social cues so they might not be very popular on the playground or on the bus.

All of this leads, quite predictably, to low self-esteem in children with ADHD, although their other symptoms draw so much attention that this very corrosive but hidden damage is overlooked by adults in their lives.

Children with low self-esteem suffer from the pain of being themselves. They learn to expect to fail rather than to succeed. They recoil from the idea of trying new things—even things they might be terrific at, like sports, or music, or dance—because they figure the odds of being naturally talented at something, or being able to patiently develop the skills to be a winner, are pretty low.

When we look at statistics on how children with ADHD fare down the line, in terms of lower-than-average educational achievement, employment, and marriage stability, one wonders how much is the disorder itself holding people back, versus how the disorder made them feel about themselves and their capabilities from earliest childhood.

The way to approach this important issue with parents and teachers is to emphasize that in treating ADHD, we should do all we can to respect the child, 24 hours a day. Beyond medication and behavior modification, we need a new sensitivity to preserving and enhancing self-esteem.

My guidelines begin with these suggestions:

► Set reasonable expectations for all children, but especially children with ADHD. When we set goals too high, they will ensure a sense of failure. In some ways, I think it is better to err slightly on the side of setting low expectations with a high probability of success.

► Expect normal variations in a child's performance. Again, all kids (like adults!) have great days of peak performance, and not-so-great days, but for kids with ADHD, the variability might be more dramatic. If we get too excited about a child with ADHD having a wonderful day of achievement and control, we risk resetting the bar too high and setting the stage for a disappointing tomorrow.

► Consider other factors. When evaluating the performance of a child with ADHD, take other factors into account: comorbidities, problems in the family, and chronic illness. See whether improvements in those other areas might boost their accomplishments.

► Focus on building strengths rather than remediating weaknesses whenever possible. An extra 2-3 hours of math tutoring is not likely to make a child with ADHD a great success at math. The same 2-3 hours after school honing a skill, whether it's a computer game or karate or ice hockey, might give the child an avenue in which to excel and provide a genuine source of pride. Keep in mind that in the long term, most people choose a career based on a strength, not a weakness they've tried to overcome.

► Think about summer as a time to take the pressure off and cultivate successes. Ask families to consider an energetic camp, one with activities suited to the individual child, rather than endless hours of academic skills building or remediation.

► Encourage play! Remind families that kids with ADHD crave moments of senseless fun with their parents. Swimming lessons are important, but so is splashing in the pool. I like to brainstorm with families about ideas for rituals in which there is no lesson to be learned or skill to be practiced, like watching a favorite (noneducational!) television show each week. Even better is to ask the child to pick an activity he or she does well—like playing computer games—and using "fun" time to teach parents how to play.

While working with these children, don't forget to ask what's great about the kid! ■

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