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LETTER TO THE EDITOR

Is symptomatic treatment an option for a boy with clinically significant psychotic-like experiences and depressed mood? Comment on Ruhrmann et al., "intervention in at-risk states for developing psychosis." (Eur Arch Psychiatry Clin Neurosci 260 Suppl 2:S90–94)

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Dear Sirs,

Bewildered by the varying manifestations of at-risk states for developing psychosis, as well as the inconclusiveness of recommended treatment strategies and the frequently changing names regarding psychotic prodrome (ultrahigh risk, late prodrome, psychosis risk syndrome, attenuated psychotic symptoms syndrome, etc.) [5, 8, 10], we clinicians are facing the challenge to provide appropriate treatment to adolescents suspected at pre-psychotic state with significant distress in our daily practice. The review by Ruhrmann et al. [7] suggests some potential interventions worth of considerations; however, given the fact that most of randomized control trials have relatively small sample sizes, we still expect to learn something from an in-depth look into a single case.

A 12-year-old Taiwanese boy used to maintain top-ranked academic performance and sound peer relationships. Known to be introverted in nature and having no family history of major psychiatric disorders, he was brought to our Child Mental Health Center for sleep problems and over-anxiousness, which were difficult to be solved by psychosocial approaches delivered by his family and school. Actually, he became oversensitive to people's appraisals 1 year ago when he got qualified to attend a talented class in the upcoming year. Since then he reported some unstable ideas of reference (people seemed to be talking about him and seeing him differently), frequent anticipatory anxiety, and one episode of immersing delusional atmosphere (feeling the world being subtly altered and becoming sinister for a few hours) 5 months ago. Then, he excessively ruminated over these psychotic-like experiences and felt depressed, apprehensive, and sleepless with bad dreams. He became socially detached because of greater stress related to his increased oversuspiciousness in recent 2 months.

Suspected being at high risk of developing psychosis, aripiprazole 3.75 mg/day was prescribed. With no significant response in the first 3 weeks, his parents decided to give him 5 mg and 7.5 mg on alternate days under our stringent supervision, and we reevaluated the boy bi-weekly. In the next 6 weeks, his ideas of reference and interpersonal oversensitivity improved gradually without significant adverse reactions. However, he still could not sleep well and felt dysphoric whenever ruminating over his previous psychotic-like experiences (PLEs), despite concomitant use of clonazepam (0.5 mg). Fluoxetine 10 mg/day was added after 2-month use of aripiprazole. After combined use of both agents for 3 months, his depressive symptoms and residual ideas of reference diminished greatly. Followed up continuously for 12 months, neither recurrence of PLEs or depression, nor adverse drug reaction was noticed. Now he can play a more active role at school.

Other than psychotic prodrome, our presented case might also be with subthreshold clinical syndromes of depression, social phobia, or merely adjustment disorder. In fear of developing psychosis, low-dose aripiprazole was given to mitigate his PLEs at first. Not knowing to be the core symptom or the residual, his depression was successfully treated by the augmentation with low-dose fluoxetine. For a 12-year-old boy in obvious distress, we were pressed to solve his imminent problems rather than waiting for more scientific evidences. Aripiprazole has established efficacy and good tolerability in adolescents with schizophrenia [1], and is beneficial to subjects at psychotic

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prodrome [3, 9]. Also, fluoxetine is generally the first choice for adolescents with depression [6]. Thus, our practice should be cautious and safe for adolescents presenting with such ambiguous manifestations [2, 7].

In light of "probably at-risk, but certainly ill" [8], early intervention for these distressed and help-seeking individuals is supposed to be given with great discretion. Hope our successful low-dose psychopharmacological augmentation strategy may not only justify its preventive benefits over risks, but also help to deal with the ethical and practical dilemma in indicated intervention [4].

Conflict of interest The authors have no conflict of interest.

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