

Invited Letter Rejoinder

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Authors' reply: Psychosis Spectrum Disorder is a clinical diagnosis

We appreciate both Curtis and Derks, and Bora for their interest in our recent viewpoint on the concept of psychosis spectrum disorder (PSD) (Guloksuz & van Os, 2017). Both letters in response to our paper raise several concerns about the PSD framework, in particular extending the boundaries of PSD to include psychotic experiences. We welcome the opportunity to reiterate our understanding of PSD in an itemized fashion:

- (1) Consistent with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) introducing 'spectrum' terminology, we proposed PSD combining all DSM5 psychotic disorders (schizophrenia, schizoaffective disorder, brief psychotic disorder, and so on) to end the illogical emphasis on schizophrenia. Thus, in contrast to DSM5 retaining the distinction between schizophrenia and other psychotic disorders, the concept of PSD takes one step forward towards a true spectrum approach, analogous to autism spectrum in DSM5. We also argue that a complete transition to spectrum approach necessitates renaming to liberate our minds.
- (2) We never claimed that schizophrenia is not a mental disorder but argued that schizophrenia is not a natural disease entity, and therefore attempts to reverse-engineer schizophrenia are destined to fail. This concern was raised by the National Institute of Mental Health and led to the founding of the Research Domain Criteria project (Cuthbert & Insel, 2010).
- (3) Evidence indicates substantial neurobiological overlap between bipolar disorder and PSD defying Kraepelin's dichotomy. DSM5 appraised these findings, separated bipolar disorders from depressive disorders, and placed it between the chapters of depressive disorders and schizophrenia spectrum and other psychotic disorders. Given accumulating data, we speculated that bipolar disorder would likely find a place within the framework of PSD in the future. At this stage, we, however, await confirmatory data. We also pointed out the need for

transdiagnostic research to embrace heterogeneity inherent to mental disorders, such as the Bipolar-Schizophrenia Network on Intermediate Phenotypes study (Pearlson *et al.* 2016).

- (4) We never suggested extending the boundaries of PSD to include psychotic experiences and beyond in clinical practice. On the contrary, we questioned the validity of the ultra-high-risk-*cum*-transition paradigm attributing special value to positive psychotic experiences rather than embracing the full range of person-specific psychopathology in identifying at-risk population – in other words, the 'pre-schizophrenia' group (van Os & Guloksuz, 2017). However, we do conclude that psychotic experiences, similar to any other subtle expression of psychopathology domains (e.g. autism, anxiety, depression, and cognition), provide an invaluable source of information to leverage our efforts in gaining insight into early psychopathology and mastering the disease phenotype in the research setting, as evidenced by abundant research.

With this opening, we wish the American Psychiatric Association to reconsider their earlier decision to relegate dimensions to the appendix and integrate dimensional assessment of eight psychopathology domains into the main text in the upcoming revision, DSM5.1, particularly in the chapter on psychotic disorders. Even this subtle revision would clear the path to test the utility of the multidimensional spectrum approach in psychosis.

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Declaration of Interest

None.

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