

# AT-RISK MENTAL STATES

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## AT-RISK MENTAL STATES

**Primary Disciplinary Field(s):** Psychology, Psychiatry, Clinical Neuroscience

### 1. Core Definition

At-risk mental states, often abbreviated as ARMS, designate a crucial, pre-syndromal phase characterized by the presence of psychological symptoms or specific vulnerability factors that significantly elevate an individual's susceptibility to developing full-blown mental illnesses, or, alternatively, engaging in severe adverse behaviors such as violence or abuse perpetration. This concept moves beyond mere genetic predisposition by focusing on observable, albeit subthreshold, clinical manifestations that signal imminent risk. It represents a critical area of focus in modern preventative psychiatry, aiming to identify individuals who are demonstrating early, subtle signs of psychological distress that have not yet met the formal diagnostic criteria for a recognized disorder, thereby differentiating them from the general population who may experience transient stress or typical emotional fluctuation. The core utility of the ARMS framework lies in its predictive power, highlighting those who are progressing along a psychopathological trajectory, making the timely deployment of targeted interventions possible before irreversible functional decline occurs.

The distinction between an individual experiencing an ARMS and one suffering from a fully established disorder is fundamental; while the symptoms in the at-risk state are noticeable and cause functional impairment, they are typically attenuated, intermittent, or limited in scope, failing to meet the required intensity or duration thresholds specified in diagnostic manuals like the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). For instance, an individual might exhibit highly suspicious thinking or transient perceptual disturbances that resolve quickly, rather than persistent, entrenched delusions or hallucinations characteristic of psychosis. Furthermore, the concept encompasses vulnerability factors beyond specific psychological symptoms, including identifiable coping deficits--such as the internalizing coping style mentioned in clinical examples--which itself increases the risk for internalizing disorders like major depressive disorder or generalized anxiety disorder. This multidimensional approach recognizes that risk stems from a complex interplay of inherent psychological mechanisms and environmental stressors.

The application of the ARMS concept is primarily associated with the prediction of schizophrenia and other psychotic disorders, where the term **Clinical High Risk (CHR)** is frequently employed interchangeably. However, the framework is expanding rapidly to encompass other major mental health challenges, including Bipolar Disorder, severe mood disorders, and the potential for increased risk of adverse behavioral outcomes. By standardizing the identification of these precursors, clinicians and researchers can pool data and refine predictive models, moving the field towards precision medicine. The objective is not simply prediction, but the application of

prophylactic strategies that either prevent the onset of the severe condition entirely or mitigate its severity, thereby drastically improving long-term prognosis and quality of life for the affected individual.

## 2. Historical Development and Evolution of Terminology

The academic interest in identifying precursors to severe mental illness has roots dating back to the early 20th century, particularly in the study of schizophrenia, where clinicians observed subtle, non-specific symptoms preceding overt psychotic breaks. However, the formal articulation and operationalization of the at-risk mental state paradigm emerged in the late 1980s and 1990s. This period was marked by a growing recognition within the psychiatric community that focusing solely on chronic, established illness was insufficient; a shift toward preventive and early intervention strategies was necessary to fundamentally alter the often devastating course of severe mental disorders. Key pioneering work, particularly from research teams in Australia (e.g., the Personal Assessment and Crisis Evaluation--PACE--Clinic in Melbourne) and Europe, provided the empirical foundation for defining specific symptom clusters that possessed sufficient predictive validity to warrant clinical attention.

The evolution of terminology reflects the refinement of diagnostic understanding. Initially, terms such as the "prodromal phase" were used, referring vaguely to the period between the appearance of initial symptoms and the full development of a disorder. This was later formalized into the concept of **Ultra-High Risk (UHR)** or Clinical High Risk (CHR) for psychosis. The UHR criteria, standardized by criteria sets like the Comprehensive Assessment of At-Risk Mental States (CAARMS) and the Structure Interview for Psychosis-Risk Syndromes (SIPS), established specific, measurable benchmarks, such as the presence of Attenuated Psychotic Symptoms (APS). This formalization allowed for standardized research protocols, enabling multi-site collaborative studies and the systematic testing of preventative therapies. The institutionalization of these criteria marked the transformation of the ARMS concept from a clinical observation into a robust, research-driven field of inquiry.

Furthermore, the expansion of the ARMS concept beyond psychosis has been a significant historical development. While the initial research focused heavily on preventing schizophrenia, contemporary research now applies similar risk stratification models to identify precursors for disorders such as major depression, bipolar disorder, and even neurodegenerative conditions. This broader application acknowledges that early indicators of vulnerability are not exclusive to one class of illness but may represent a general psychological instability or neurobiological dysregulation that manifests differently depending on genetic and environmental inputs. The focus has shifted from defining a rigid diagnostic entity to establishing a continuum of risk, where ARMS represents the crucial threshold signaling the need for prophylactic intervention, cementing its role as a cornerstone of modern preventative mental health care.

### 3. Identification and Assessment Criteria (Symptom Clusters)

The identification of an at-risk mental state relies heavily on standardized interview tools designed to detect subthreshold symptoms and calculate cumulative risk scores. The most widely accepted assessment criteria for defining the high-risk state, particularly for psychosis, typically fall into three major categories. The first and most common category is the presence of **Attenuated Psychotic Symptoms (APS)**, where an individual experiences transient, mild forms of delusions, hallucinations, or disorganized speech that are below the required threshold for a psychotic disorder. These symptoms must have emerged or worsened significantly over the past year and must be sufficiently bothersome to cause demonstrable distress or functional decline, distinguishing them from fleeting, non-clinical experiences.

The second major criterion is the presence of **Brief Limited Intermittent Psychotic Symptoms (BLIPS)**. This category encompasses symptoms that meet the full diagnostic criteria for a psychotic episode in terms of severity and quality, but are extremely short-lived, resolving spontaneously within a week without pharmacological intervention. The presence of BLIPS suggests a high degree of immediate vulnerability, as the individual has demonstrated the capacity to transition into a full psychotic state, even if only briefly. Clinical assessment must carefully distinguish BLIPS from established but remitting psychosis, often requiring detailed longitudinal history to ensure the individual is truly in an at-risk phase rather than a recovery phase of a previously diagnosed disorder.

The third set of criteria focuses on **Genetic Risk and Functional Decline (GRFD)**. This applies to individuals who do not exhibit APS or BLIPS but possess a strong family history of psychotic disorder in a first-degree relative (e.g., parent or sibling), coupled with a significant recent deterioration in functioning, such as a substantial drop in academic performance, social withdrawal, or inability to maintain employment. The GRFD criterion acknowledges that genetic vulnerability combined with environmental or developmental stressors manifesting as functional impairment presents a substantial, independent risk factor. Tools such as the Structured Interview for Psychosis-Risk Syndromes (SIPS) and the Comprehensive Assessment of At-Risk Mental States (CAARMS) systematically map these criteria, allowing clinicians to quantify the level of risk and monitor symptomatic progression with precision.

### 4. Etiology and Vulnerability Factors

The development of an at-risk mental state is understood through a complex diathesis-stress model, integrating biological, psychological, and environmental factors that contribute to overall vulnerability. Biologically, research points toward subtle neurodevelopmental abnormalities, particularly concerning connectivity and gray matter volume in key brain regions such as the prefrontal cortex and the hippocampus, areas critical for executive functioning, memory, and

emotional regulation. Studies often reveal dysregulation in neurotransmitter systems, especially the dopaminergic system, which is hypothesized to contribute to the emergence of attenuated positive symptoms like mild paranoia or suspiciousness. Genetic studies further confirm a polygenic risk profile, meaning that ARMS is not caused by a single gene but by the cumulative effect of many common gene variants, each contributing a small portion to the overall predisposition toward mental instability.

Psychological factors play an equally crucial role in determining whether underlying biological vulnerability translates into observable ARMS. Cognitive deficits, particularly in areas of processing speed, attention, and theory of mind (the ability to understand others' perspectives), are frequently identified in individuals at high risk. Furthermore, specific coping mechanisms, such as excessive avoidance or, as noted in the original source content, an **internalizing coping style**, significantly contribute to the risk profile. Internalizing coping involves directing stress inward, often leading to rumination, emotional suppression, and increased susceptibility to mood disorders like depression and anxiety, which frequently co-occur with or precede the onset of psychotic symptoms. These coping mechanisms act as proximal risk multipliers, exacerbating the impact of stressors.

Environmental and social factors often serve as the catalysts that push a vulnerable individual into an ARMS. High levels of chronic or acute stress, particularly during critical developmental windows like adolescence and early adulthood, are strongly implicated. Adverse childhood experiences (ACEs), including trauma, abuse, and neglect, represent potent risk factors that can alter brain development and psychological resilience, predisposing the individual to mental health crises later in life. Additionally, social factors such as low socioeconomic status, minority stress, social isolation, and exposure to urban environments or migration stress have been consistently linked to increased prevalence of ARMS, highlighting the critical interaction between personal vulnerability and the broader socio-ecological context in determining the trajectory toward severe mental illness.

## 5. Significance: Early Intervention and Prevention

The primary significance of the ARMS concept lies in its capacity to delineate a critical window for intervention, allowing for the application of true secondary prevention strategies aimed at mitigating the severity of symptoms or preventing the progression to a full-threshold disorder. If severe mental illnesses, especially psychotic disorders, are allowed to develop unchecked, they often result in significant brain changes, functional decline, and severe psychosocial consequences that become increasingly refractory to treatment. By identifying individuals in an ARMS, clinicians can intervene before the onset of the first episode of psychosis (FEP), a period often associated with intense neurotoxicity and long-term functional loss. This preventive approach represents a paradigm shift from reactive crisis management to proactive risk mitigation.

Interventions employed in the ARMS population are typically multimodal and less aggressive than

those used for established disorders. Psychological treatments, primarily **Cognitive Behavioral Therapy (CBT)** tailored for Attenuated Psychotic Symptoms (CBT-p), are often the first line of defense. CBT-p helps individuals challenge distorted thoughts, manage stress, and improve coping skills, directly addressing the underlying psychological vulnerabilities. Furthermore, supportive psychotherapies and psychoeducation are essential for managing anxiety surrounding the risk status and improving social functioning, which is frequently compromised in this population. The goal is functional recovery and resilience building, irrespective of whether the individual progresses to a full disorder or not.

Pharmacological interventions are approached with significant caution due to ethical concerns regarding the use of potent medications in non-psychotic individuals. However, specific nutrient interventions, such as supplementation with Omega-3 fatty acids, have shown promising results in some randomized controlled trials as a safe, neuroprotective strategy. Low-dose antipsychotic medication may be considered for those at extremely high risk or with severely distressing attenuated symptoms, but this decision is typically reserved for cases where psychological interventions have failed and the risk of transition is deemed imminent and severe. The emphasis remains on minimizing medication exposure while maximizing functional and symptomatic improvement through psychosocial support and targeted psychological therapies.

## 6. Debates and Ethical Criticisms

Despite the clinical imperative for early intervention, the ARMS concept is subject to intense academic and ethical debate, primarily centered on the issue of predictive accuracy and the potential for harm associated with premature labeling. While risk assessment tools possess reasonable sensitivity, their specificity--the ability to correctly identify only those who will convert to a full disorder--remains imperfect. Studies show that a significant percentage of individuals identified as high-risk will not progress to psychosis; this rate of "false positives" ranges widely but is often reported to be around 70-80%. This leads to the fundamental ethical dilemma: is it justifiable to intervene, potentially using medication or intensive therapy, in four individuals who would have remained well, in order to successfully prevent one transition?

A core criticism revolves around the potentially damaging effects of **labeling and stigma**. Identifying a young person as "at-risk" for a severe mental illness like schizophrenia can generate profound anxiety, self-stigma, and social withdrawal, potentially leading to iatrogenic harm--harm caused by the intervention itself. Such a label might influence educational or employment opportunities, or alter the family's expectations and treatment of the individual, irrespective of whether the full illness ever develops. Critics argue that the concept risks pathologizing normal adolescent distress or transient psychological coping difficulties, potentially expanding the boundaries of psychiatric intervention into areas that require non-clinical support.

Furthermore, there are economic and resource-allocation concerns. The intense monitoring and specialized psychological therapies required for the ARMS population are costly, raising questions about whether these resources could be better utilized treating established illnesses or focusing on broader public mental health initiatives. Researchers continuously strive to refine risk prediction models, integrating biomarkers (e.g., neuroimaging, genetic markers) to improve specificity and reduce the false positive rate, thereby strengthening the ethical justification for targeted intervention. The ongoing debate emphasizes the need for careful, patient-centered communication and the consistent use of the least invasive, most evidence-based interventions available within the ARMS framework.

## 7. Further Reading

[Clinical high risk for psychosis \(Wikipedia\)](#)

[Omega-3 fatty acids for the prevention of psychosis: systematic review and meta-analysis \(Academic Source\)](#)

[Comprehensive Assessment of At-Risk Mental States \(CAARMS\) \(Wikipedia\)](#)

[Prodromal symptoms and the risk of psychosis: current status and future directions \(Academic Review\)](#)