

Prognostic implications of paranoia and thought disorder in new onset psychosis

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Abstract

This study follows a group of 174 young people with new onset of schizotypal symptoms and examines factors which may lead to conversion to psychosis. These prodromal subjects were screened for symptoms and later given the Structured Clinical Interview of DSM-III-R at one year, two years and ten years post onset. We also included the Paranoia Scale of Fenigstein and Venable and the Scale for Thought, Language and Communications of Andreasen in all interviews. Our analysis found that the addition of scales for paranoia and thought disorder enhanced prediction of conversion to psychosis and long term outcome. The early occurrence of ideas of reference and poverty of thought appear to be significant predictors of future deterioration even when considered among other high-risk variables.

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1. Introduction

The ability to predict the outcome of an illness has always been an important part of medical science. Similarly, many psychiatric syndromes have mild symptoms that appear prior to the development of major illness. The use of prodromal terminology was introduced by Mayer-Gross in the early 20th century [1]. In recent years there has been increased interest in prognostic features of the schizophrenic prodroma [1–9]. The factors which predict conversion to psychosis are now the focus of considerable new research [2]. Several factors such as high genetic loading and substance abuse are known to be associated with poor outcome for many patients with prodromal symptoms [2–7]. Early onset of paranoia and thought disorder has also been noted as factors which may predict conversion into psychosis [8–10]. The use of psychiatric symptoms to examine the patient's progress has valuable clinical implications. With the development of prevention models in psychiatry, the ability to predict the course of an illness early on is gaining greater clinical importance [7–9,11]. The use of valid and reliable instruments to rate

symptoms is, therefore, critical for proper longitudinal study of clinical syndromes over time. By using operational criteria in prospective work, the relative risk associated between early symptoms and later outcome can be assessed with a higher degree of precision.

Paranoid thinking has long been suspected to be a risk factor for the development of schizophrenia, yet it has not been well studied with operational criteria until recently [6,9,12,13]. Since unusual notions are found in normal populations and in a variety of syndromes [13–16], it is important to determine which cases are benign and which are more likely to deteriorate. It is, therefore, vital to ascertain which individuals with peculiar thinking are most at risk for decompensation. The Scale for Thought, Language and Communication (TLC) of Andreasen has been a very reliable standard for the evaluation of thought disorder for quite some time [17] and was chosen as one scale for examination of these problems. Fenigstein and Venable have developed a scale for measuring paranoia that is both reliable and valid. This was used to examine paranoid thinking in detail [18]. By inclusion of these detailed scales, along with other measures, we hoped to determine the relative value of thought disorder and paranoia in the prediction of prognosis in early cases of prodromal illness.

This project was designed to examine the effect of early symptomatology on both conversion to psychosis and also

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on long term prognosis. We wanted to assess the relative value of symptomatic and demographic variables at one year, two year and ten year intervals after the first onset of psychological impairment (Tables 1–6). We examined symptoms in subjects with the onset of new psychiatric symptoms (in the first 6 months) and followed up to see how these people progressed over the next ten years. Our efforts were concentrated on new cases of emotional illness regardless of their diagnosis. We thought that the addition of specific scales for thought disorder and paranoia would enhance prediction for conversion and later outcome.

2. Methods

This was a prospective follow-up of patients with the new onset of psychiatric symptoms. These subjects were collected from mental health clinics and hospitals in Western Texas. Appropriate permission was obtained from the proper ethics and institutional review board before the study and all subjects gave informed consent to be interviewed. Subjects were at least 18 years old at the time of enrollment and were primarily English speaking. Each subject was screened to assess the presence of prodromal symptoms (these were essentially new onset of schizotypal symptoms of 6 months duration or less) by the author, JW. We did initial recruitment from the years 1997–2003. Patients were subsequently followed at intervals of one, two and ten years. We screened 200 original subjects. Our recruitment was successful and 87% of potential subjects agreed to participate. Each person provided demographic information about their family history, education, drug use and age of onset of psychiatric symptoms. Each subject was also interviewed using the Paranoia Scale (PS) [18], Scale for the Assessment of Thought, Language and Communication (TLC) [17], the Brief Psychiatric Rating Scale (BPRS) [19] and the SCID [20].

The administration of the TLC was done in the manner of Andreasen [17]. This required a 45 minute interview con-

Table 1

Demographic and symptomatic variables associated with conversion to psychosis at 1st year of follow up.

Variable	r	Significance
Level of education	.09	p > .05 NS
Affective symptoms	.04	p > .05 NS
Positive family history	.32	p < .05
Unusual thoughts	.65	p < .001
Paranoia	.77	p < .001
Substance abuse	.19	p < .05
Gender	.08	p > .05 NS
Age onset	.09	p > .05 NS
Hallucinations	.18	p < .05
Poverty of thought	.79	p < .001

Table 2

Correlation of BPRS scores to original index factors in converters at 1 year.

Variable	r	Significance
Positive family history	.17	p < .05
Unusual thoughts	.61	p < .001
Paranoia	.62	p < .001
Substance abuse	.18	p < .05
Poverty of thought	.70	p < .001

ducted in a standardized nonclinical format. The subject was allowed to talk about themselves for about 15 minutes. The topics were neutral and discussion of symptoms was avoided. Ratings were done by taking notes and then transferred to score sheets immediately afterward. The interviewer was kept blinded to the diagnosis of the subject.

The Paranoia Scale used in this study was designed to detect symptoms in nonclinical populations and was, therefore, appropriate to capture subtle changes of the prodromal phase. Using this method of recruitment, we were able to enroll 174 subjects in the study. Follow up interviews using the PS, TLC, SCID and BPRS were conducted one, two and ten years after the initial assessment. All assessments were done by investigators JW and SQ. Kappa scores for reliability between the two raters were found to be high (.89). The mean age of subjects was 21 years with a range of 18–26 years. Eighty nine of the subjects were male. All subjects were in good physical health.

3. Statistical analysis

Analysis of findings used Chi square test where appropriate. Student's t test was used as appropriate. Pearson correlations were run to examine random correlations of possible interactions. Multiple regression analysis was performed to evaluate variation in effect of demographics, BPRS, and TLC and PS scores at one year, two years and ten years, as a method of assessing effects upon symptom variation over time. SCID findings at these intervals were assessed for diagnosis separately as qualitative data using appropriate logistic analysis. A separate analysis was performed to evaluate the impact of demographic information, the initial TLC and PS scores on later diagnoses as indicated by SCID exams at follow up. Statistical tests were conducted 2 tailed, using an alpha value of .05, unless otherwise noted. Multivariate analysis

Table 3

Overall regression analysis of significant predictive factors for conversion at 1 year.

Variable	F value	Significance
Substance abuse	3.84	p < .05
Positive family history	3.90	p < .05
Poverty of thought	7.77	p < .001
Paranoia	7.50	p < .001

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