



# The relationships between symptom dimensions and dysphoria in schizophrenia

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Received 18 November 2003; received in revised form 27 May 2004; accepted 4 June 2004  
Available online 25 August 2004

## Abstract

Previous studies have suggested that qualitatively distinct aspects of dysphoria (anxiety and depression) are related to specific dimension of schizophrenia symptomatology. Most of these studies used simple dimensions and dysphoria models, although finer distinctions could help defining specific relationships. This study examined the relationships of distinctive aspects of depression and anxiety (both state and trait) with symptom dimensions. Forty patients with a DSM-IV diagnosis of schizophrenia were assessed for symptoms (SAPS-SANS), trait and state anxiety (STAI) and depression (CDS). Symptoms ratings were summarized as dimensional scores according to a two-, three- or five-dimensional models proposed in the literature. The correlation analysis replicates previous observations that distinct aspects of dysphoria are associated with specific dimensions of schizophrenia, with the exception of disorganization. Moreover, controlling for intercorrelated variables revealed that schizophrenia and dysphoric symptoms might act in combination and/or through indirect links to contribute to illness expression. Our data further suggested that these associations may be best understood in terms of interactions between various processing biases alluded in the most recent cognitive accounts of schizophrenia symptoms.

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*Keywords:* Schizophrenia; Symptom dimensions; Depression; Anxiety; Hallucination; Delusion; Cognitive bias

## 1. Introduction

Heterogeneity of symptoms has appeared as a major fact since the early descriptions of schizophrenia by Bleuler (1911) and Kraepelin (1919). In the 1970s,

dichotomic concepts differentiating positive and negative forms of schizophrenia have developed based on anatomic-clinical correlations (Crow, 1985; Andreasen and Olsen, 1982). For several decades, rating scales have been developed to explore the clinical and neural correlates of these two symptom dimensions. More recently, factor analytic techniques applied to rating scales examined the interrelationships between positive and negative symptoms. Review of these studies

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indicates that three rather than two dimensions better account for the symptomatology seen in schizophrenia (Liddle, 1987; Peralta et al., 1992; Andreasen et al., 1995). For instance, the ‘Psychomotor Poverty’ dimension (i.e., poverty of speech decreased spontaneous movements and blunting of affect) grossly corresponds to the original concept of negative symptoms, while the positive symptoms subdivides into two dimensions: a ‘Disorganization’ dimension (including thought disorders, inappropriate affect, poverty of content of speech and disorganized behavior) and a ‘Psychotic’ or ‘Reality Distortion’ dimension (hallucinations, delusions and thought disorders). More recent models emphasizing the heterogeneous nature of the psychotic dimension further dissociate an ‘Auditory Hallucinations’ or ‘Schneiderian’ dimension from ‘Bizarre Delusions’ or paranoid dimension (Vasquez-Barquero et al., 1996; Toomey et al., 1997; Peralta and Cuesta, 1999). This distinction is supported by the observation that hallucinations and delusions can occur independently in schizophrenia as well as in other psychiatric and organic disorders. Furthermore, the heterogeneity of the negative dimension has been also addressed. More specifically, symptoms of ‘Disordered Relationships’ long thought to be independent of other negative symptoms (Strauss et al., 1974) have been identified as an independent dimension in many factor-analytic studies (Keefe et al., 1992; Peralta et al., 1994; Toomey et al., 1997; Nakaya et al., 1999; Marengo et al., 2000) (Appendix B).

Although the physiopathological validity of the main dimensions received strong support from studies showing that each dimension has distinct cognitive (Liddle and Morris, 1991; Cuesta and Peralta, 1995; Norman et al., 1997; Guillem et al., 2001), structural (Chua et al., 1997; McIntosh et al., 2001), metabolic (Liddle et al., 1992; Kaplan et al., 1993) and neurophysiological correlates (Harris et al., 1999; Williams et al., 2000), the number of relevant dimensions remains a matter of debate (Smith et al., 1998; Stuart et al., 1999). Apart from methodological differences, the discrepancies between studies can be associated with dimensional variations according to the patient’s status (first episode vs. chronic schizophrenia) (McGorry et al., 1998; Vasquez-Barquero et al., 1996), phase of the illness (remitted vs. acute phase) (Mellers et al., 1996; Nakaya et al., 1999; Lançon et al., 2000), age (Sauer et al., 1999; Schultz et al., 1997;

Marengo et al., 2000), illness onset and duration (early vs. late onset) (Häfner et al., 1998; Mojtabai, 1999) and antipsychotic medication status (Molina-Rodriguez et al., 1998; Meagher et al., 2001). In summary, there is accumulating evidence that nonspecific temporal factors and/or state-dependent factors interact with the symptoms of schizophrenia to determine the expression of the illness. It is possible that dysphoric states play an important role as factors in determining the expression of schizophrenia. Dysphoria includes both anxiety and depression (Stedman, 1995; Taber, 1997). Similar to the symptom or dimensions of schizophrenia, it is well known that both aspects of dysphoria vary from time to time (i.e., mood states) as well as across the life span (Krasucki et al., 1998; Henderson et al., 1998; Karel, 1997; Form, 2000). Research in schizophrenia has also typically associated anxiety with positive symptoms (Ciompi, 1994; Kingdon and Turkington, 1994) and depression with negative symptoms (Knights and Hirsch, 1981; Zubin, 1985).

In spite of the growing importance of the dimensional approach of schizophrenia, only a few studies have attempted to elucidate the actual relationships between the symptom dimensions and the various aspects of dysphoria. In their ‘pyramidal model of schizophrenia’, Kay and Sevy (1990) initially inferred a ‘depressive’ dimension including both the anxious and depressive aspects of dysphoria as a key element contributing to the paranoid expression when associated to positive symptoms and to the catatonic expression when associated with negative symptoms. However, the first study to examine directly the correlations between dysphoria and positive vs. negative symptoms was that of Norman and Malla (1991) who found dysphoria to be significantly related to positive but not negative symptoms. Subsequently, in a longitudinal study, these same authors (Norman and Malla, 1994a,b) reported a greater likelihood of positive correlations in changes over time between dysphoria and positive rather than negative symptoms. This association has been replicated later by others (Lysaker et al., 1995; Nakaya et al., 1997) and by Sax et al. (1996) who reported evidence of a more specific correlation between depression and positive symptoms. In a more recent study, Norman et al. (1998) examined further these relationships using a three-dimensional model of schizophrenia symptomatology while separating the anxious and depressive aspects of

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