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Schizotypal personality disorder or prodromal symptoms of schizophrenia?

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Abstract

Schizotypal personality disorder shares some attenuated phenotypic features with schizophrenia, but represents an independent syndrome. In contrast, prodromal symptoms of schizophrenia represent early warning signs of the impending onset of schizophrenia. Although these constructs are intended to reflect independent syndromes, self-report instruments measuring these constructs assess similar symptoms. It does not appear that existing research has examined the relative discriminant validity of screening instruments for these syndromes. A sample of 998 young adults (68% female; 73% Caucasian), within the age of risk for schizophrenia (ages 18–34; mean 20.4 ± 2.2), met validity criteria after completing online versions of the Abbreviated Schizotypal Personality Questionnaire (SPQ-B) and the 24-item Abbreviated Youth Psychosis at Risk Questionnaire (Y-PARQ-B). Based on clinical cut-off scores used in previous research, 5.2% were [only] considered at heightened risk for psychosis (potentially prodromal), 3.4% had [only] schizotypal personality features, and 2.9% met criteria for both constructs (75% of individuals meeting cutoff for one measure did not meet criteria for the other). Males and younger participants scored significantly higher on both measures. The total scores from the SPQ-B and Y-PARQ-B showed a significant positive correlation ($r_s = .66$, $p < .001$, $R^2 = .43$); however, 57% of the variance was not shared between the measures. Of the three SPQ-B subscales, Cognitive–Perceptual showed the strongest correlation with Y-PARQ-B. Results suggest that the SPQ-B and Y-PARQ-B have moderate discriminate validity between the overlapping, yet distinct, constructs of schizotypal personality and heightened risk of developing psychosis (potentially prodromal).

Keywords: Schizotypal; Prodromal; Schizophrenia; Discriminant validity; At-risk

1. Introduction

Recent research has endeavored to identify clinical presentations that predict later onset of schizophrenia (Corcoran et al., 2003; T.J. Miller et al., 2003; Yung et al., 2003). Individuals who present with subthreshold characteristics of schizophrenia,

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but who do not yet meet full criteria for the disorder, are said to be in a "prodromal" phase and are at significantly higher risk of developing schizophrenia in the following 1 to 5 years (T.J. Miller et al., 2003; Yung et al., 2003). However, it is important to note that the existence of a "prodromal" phase can only be confirmed retrospectively, using the onset of schizophrenia as the criteria. In contrast, persons diagnosed with DSM-IV schizotypal personality disorder (SPD) experience a chronic constellation of similar symptoms, but are not at higher risk than the general population for later development of schizophrenia (American Psychiatric Association, 1994). While these two syndromes reflect differential risk for development of schizophrenia, they share many of the same symptoms, which include perceptual distortions, magical ideation, interpersonal deficits, and odd or eccentric behavior. One difference in these constructs is that prodromal measures aim to assess a construct of declining functioning and increasing symptom severity associated with impending onset of schizophrenia (a change in functioning; T.J. Miller et al., 2003). On the other hand, schizotypal measures aim to assess longstanding chronic symptoms associated with SPD, which is thought to represent a clinical endpoint. As personality disorders are often not evident until early adulthood, distinguishing prodromal symptoms of schizophrenia from SPD becomes particularly difficult during adolescence and early adulthood—as both syndromes may present as relatively new features during this period of development.

Previous studies have highlighted the usefulness of studying SPD to promote insight into the prodromal phase of schizophrenia (Seeber and Cadenhead, 2005; K.S. Cadenhead, 2002). These studies have noted the use of schizotypal personality disorder criteria in the development of structured prodromal screening criteria in various research centers and clinics, and the increased frequency of SPD in families of those diagnosed with schizophrenia. However, it remains unclear how the similar diagnostic criteria can optimally differentiate individuals with SPD as a clinical endpoint from those with similar symptoms that represent the prodromal phase of schizophrenia—particularly in a younger population within the age of risk for schizophrenia. Another study noted similarities between neurocognitive abnormalities in persons diagnosed with SPD and schizophrenia, but suggested that individuals with SPD may have relatively preserved frontal lobe volumes (Siever and Davis, 2004). This neurocognitive finding suggests that while there may be considerable overlap between endophenotypic features of SPD and schizophrenia, there may be unique features that aid in the prediction of the clinical endpoint. As this study focused on individuals already diagnosed with chronic schizophrenia, further research is needed to determine if frontal lobe morphology and/or functioning differs in those with persisting SPD compared to individuals in the prodromal phase who later convert to schizophrenia.

Self-report screening measures have been developed to measure schizotypal symptoms (Raine, 1991) and symptoms suggesting heightened risk of developing psychosis ("potentially prodromal"; Ord et al., 2004). These measures provide an efficient means of screening a large number of individuals to identify those in need of further assessment with more lengthy and costly clinician-administered interviews. While these measures inevitably inquire about similar attenuated symptoms of schizophrenia, they are ultimately aiming to assess two different constructs. Curiously, most of these self-report screening measures do not inquire about the chronicity of the symptoms, which may improve the ability of these measures to distinguish between these overlapping constructs.

It does not appear that previous reports have examined the discriminant validity between self-report measures of schizotypal personality disorder and heightened risk of developing psychosis. It is possible that the measures of these symptoms overlap to the degree that they are essentially measuring the same construct. On the other hand, the measures may be measuring two different constructs as intended. Understanding this discriminant validity is crucial for proper interpretation of research that includes these scales. Therefore, the purpose of this study is to examine the discriminant validity of a common self-report measure of schizotypal personality disorder to a new and promising self-report measure of heightened risk of developing psychosis. It was hypothesized that the two measures will show poor discriminant validity, as they appear to measure very similar symptoms.