Negative symptoms in individuals at clinical high risk of psychosis


1. Introduction

Recent advances in research in early detection of psychosis have led to the development of reliable criteria to identify individuals who may be at risk of developing psychosis and thus potentially experiencing a prodrome for psychosis (Yung and McGorry, 1996b; McGlashan et al., 2010). These prospective studies rely primarily on the presence of attenuated positive symptoms and decreased functioning (Yung and McGorry, 1996b; McGlashan et al., 2010). However, significant proportions of these individuals have non-specific symptoms (e.g. depression and anxiety) as well as negative symptoms, such as social isolation/withdrawal, and reduced motivation (Lencz et al., 2004). This finding pertaining to the construct of amotivation or avolition is in agreement with findings from patients with schizophrenia (Faerden et al., 2009). Interestingly, it is these behavioural and functional changes that are often the first reasons for seeking help (Yung and McGorry, 1996a; Lencz et al., 2004). Relative to attenuated positive symptoms, the prevalence of negative symptoms is high (Yung et al., 2003; Lencz et al., 2004; Velthorst et al., 2009), among of which social isolation and deterioration in role (school) functioning are most frequently reported (Lencz et al., 2004). Furthermore, negative symptoms, especially increased social isolation and withdrawal, have been reported to be predictive of transition to psychosis (Kwapil, 1998; Mason et al., 2004; Yung et al., 2005; Velthorst et al., 2009). In the Edinborough longitudinal study of individuals at genetic high risk of psychosis (Johnstone et al., 2005), social withdrawal and isolation, as measured on the Structural Interview for Schizotypy, emerged as the strongest discriminator between those who converted and those who did not.

Typically, negative symptoms are examined as one construct, although there are reports of negative symptoms clustering into two domains of diminished expression (i.e. affective flattening and poverty of speech) and amotivation (i.e. avolition/apathy and anhedonia/asociality) (Mueser et al., 1994; Sayers et al., 1996). More recently
there has been a focus on differences among individual negative symptoms with suggestions that “avolition” is a core negative symptom with a direct impact on both functional outcome and cognitive function (Foussias and Remington, 2010).

Previous studies of the psychosis prodrome that explored the predictive value of negative symptoms to psychosis conversion have done so using different instruments to assess prodromal symptoms. Whereas some studies used scales designed to rate the severity of sub-psychotic level symptoms (Yung et al., 2005; Velthorst et al., 2009) others used conventional rating scales for psychotic-level symptoms (Mason et al., 2004) or a scale designed to assess a single symptom (Kwapil, 1998). Furthermore, none of the studies included longitudinal examination of negative symptoms. Thus, the goal of the present investigation was to examine in more detail negative symptoms in a sample of individuals described as being at clinical high risk (CHR) of developing psychosis. The specific aims were: 1) to determine the prevalence of individual negative symptoms; 2) to determine the stability of negative symptoms, 3) to explore the factor structure of positive and negative symptoms of the SOPS, and 4) to explore longitudinally the role of negative symptoms in conversion to psychosis.

2. Methods

2.1. Participants

The North American Prodrome Longitudinal Study (NAPLS-1) project is a consortium of eight research sites that investigated the earliest phase of psychotic illness, with the goal of improving the accuracy of prospective prediction of psychosis (Addington et al., 2007; Cannon et al., 2008). All sites recruited CHR individuals and followed them up for a period of up to 2.5 years during the period 2000–2006. Although initially developed as independent studies, the investigations at eight sites employed similar ascertainment and diagnostic methods (i.e. Structured Interview for Prodromal Symptoms - SIPS; McGlashan et al., 2010) making it possible to form a standardised protocol for mapping data into a new scheme representing the common components across sites (Addington et al., 2007). The study protocols and informed consents were reviewed and approved by the ethical review boards of all eight study sites. Methods and details of the NAPLS-1 are reviewed in detail elsewhere (Addington et al., 2007; Cannon et al., 2008).

Three hundred and seventy-two participants met one of the three established criteria for a psychosis risk syndrome, namely: attenuated psychotic symptom state (APSS), brief intermittent psychotic symptom state (BIPS) and genetic risk with deterioration (GRD). Criteria for a prodromal syndrome and criteria for conversion to psychosis were determined using the Structured Interview for Prodromal Syndromes (SIPS) (McGlashan et al., 2010). Conversion meant that at least one of the five attenuated positive symptoms reached a psychotic level of intensity (rated 6) for a frequency of ≥ 1/h day for 4 days/week during the past month or that symptoms seriously impacting functioning (e.g. severely disorganised or dangerous to self or others) (McGlashan et al., 2010). All NAPLS sites demonstrated reliability in rating criteria (>80% ranged from 0.80 to 1.00 across sites) (Addington et al., 2007).

The Structured Clinical Interview for DSM-IV (SCID-I) (First et al., 1995) was used to determine the presence of any axis I disorders. Participants were excluded if they met criteria for any current or lifetime axis I psychotic disorder, IQ <70 or past or current history of a clinically significant central nervous system disorder which may confound or contribute to prodromal symptoms.

For this project we included only participants who had completed the negative symptom ratings at both 6- and 12-month follow-up. Thus, participants were 50 females and 88 males. At ascertainment, the mean age was 18.6 years (S.D. = 4.88). On average participants had 10.7 years of education (S.D. = 3.25) with 91 participants (66.0%) attending high school and 18 (13.0%) attending college. Twenty-six participants (19.0%) were employed full-time. Sixty-six participants (48.0%) met DSM-IV criteria for any current or lifetime axis I psychotic disorder, IQ ≥ 70 or past or present history of a clinically significant central nervous system disorder which may confound or contribute to prodromal symptoms. At ascertainment, the mean age was 18.6 years (S.D. = 4.88). Males had more severe negative symptoms (M = 13.60, S.D. = 7.25) compared to females (M = 8.86, S.D. = 6.58, t = −3.81, P = 0.001).

Reported prevalence for specific negative symptoms of ≥3 severity rating at baseline 6- and 12-month follow-up are displayed in Fig. 1. A majority of participants (82.0%) at the start of the study endorsed at least one negative symptom rated ≥3 on the SOPS (i.e. moderate to above moderate severity). Sixty-one (44.0%) participants reported at least one symptom in the moderate to above moderate range (i.e. SOPS ratings of 3 and 4), and 52 (38.0%) participants reported symptoms in the severe range (i.e. SOPS ratings of 5 and 6). Males had more severe negative symptoms (M = 13.60, S.D. = 7.25) compared to females (M = 8.86, S.D. = 6.58, t = −3.81, P = 0.001).

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Note: a, significantly different from baseline at P<0.05 level b, significantly different from 6-months at P<0.05 level

Fig. 1. Prevalence of reported negative symptoms rated ≥3 at baseline, 6 and 12 months.
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