MANAGEMENT OF PRIMARY NEGATIVE SYMPTOMS IN SCHIZOPHRENIA: AN ONE-YEAR OBSERVATIONAL STUDY

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SUMMARY
Negative symptoms represent a separate symptom domain, with respect to depression, neurocognition, and social cognition and have a strong direct and indirect impact on real-life functioning. Furthermore, negative symptoms that do not improve following antipsychotic treatment are an important diagnostic and therapeutic challenge. We conducted a 12-month-study open-observational study to evaluate the efficacy of some atypical antipsychotics on negative symptoms, according to the following recommendations of Consensus Development Conference Attendees. In our study, we evaluated in an open-label study the efficacy of some second-generation antipsychotics (olanzapine, quetiapine, clozapine, and risperidone) in 42 patients with schizophrenia or schizoaffective disorder (DSM-5 criteria) with 'persistent negative symptoms'. We used different rating scales (PANSS, CDS, BNSS, BPRS), but mainly we focused on the new Brief Negative Symptoms Scale (BNSS) for negative symptoms. Our total data indicate an overall statistically significant reduction in all scales, although not clinically relevant.

Key words: negative symptoms – BNSS - schizophrenia

INTRODUCTION
Negative symptoms have long been recognized as a central feature of the phenomenology of schizophrenia (Kraepelin 1919, Bleuler 1908). They represent a separate symptom domain, with respect to depression, neurocognition, and social cognition (Foussias 2014, Kirkpatrick 2014), and have a strong direct and indirect impact on real-life functioning. Furthermore, negative symptoms that do not improve following antipsychotic treatment are an important diagnostic and therapeutic challenge. The presence of a significant decrease in behavioural or psychological function, including problems with motivation, social withdrawal, diminished affective responsiveness, speech and movement, contribute more to poor functional outcomes and quality of life for individuals with schizophrenia than to positive symptoms (Peralta 2014, Galderisi 2008). Effectively, negative symptom severity has been consistently linked to worse functional outcomes in schizophrenia, including specific relationships with impaired occupational functioning, household integration, social functioning, engagement in recreational activities, quality of life and finally, these symptoms lead to worse functional outcomes (Chan 2015, Strauss 2013, Rabinowitz 2012, Blanchard 2005).

PERSISTENT NEGATIVE SYMPTOMS
The current consensus definition of negative symptoms in schizophrenia includes symptoms of affective flattening, alopecia, avolition, asociality and anhedonia. Symptoms of inattention, poverty of speech, and inappropriate affect, traditionally included in some measures of negative symptoms, are seen to align more closely with clinical ratings of disorganization seen in schizophrenia (Foussias 2014). The term negative symptoms includes primary and secondary negative symptoms; the former refers to the symptoms that are intrinsic to schizophrenia, the latter refers to symptoms caused by positive symptoms, affective symptoms, medication side-effects, environmental deprivation or other treatments (Ahmed 2015, Carpenter 1985). The term 'deficit symptoms' is used to refer to primary and enduring negative symptoms that represent the core aspect of a putative schizophrenia subtype (Kirkpatrick 2014, Buchanan 2007, Carpenter 1988). However, the categorization of subjects into deficit and nondeficit forms of schizophrenia may be difficult in the clinical context. The concept of persistent negative symptoms represent a broader concept than the deficit syndrome; the classification can be completed using any of the accepted and validated negative symptom scales (Galderisi 2013). 'Persistent negative symptoms' differ from deficit symptoms in several aspects. The most important differences are the duration and the severity (at least 12 months in deficit symptoms; at least six consecutive months with moderate or worse severity).

"In consequence, persistent negative symptoms identify a patient population with a clinically relevant symptomatology large enough to be targeted, selected, and studied" (Buchanan 2007).

However, it was necessary to find assessment tools that could facilitate the study of this symptomatology. Based on these observations, in 2005 Carpenter co-chaired the Consensus Development Conference on Negative Symptoms sponsored by the US National Institute of Mental Health (Kirkpatrick 2006). The Conference resulted in a recommendation that a new instrument for quantifying negative symptoms be developed. Two instruments grew out of the recommendation: the Brief Negative Symptoms Scale (BNSS) (Kirkpatrick 2011) and the Clinical Assessment Interview for Negative Symptoms (CAINS) (Kring 2013).