Signs & Symptoms – Negative Symptoms

Introduction

The ‘negative symptoms’ of schizophrenia refer to an absence of normal functions. This may include (but is not limited to) blunted affect, which is a scarcity of facial expressions of emotion, reduced frequency and range of gestures and voice modulation, and restricted eye contact; alogia (poverty of speech); asociality (reduced social interaction); avolition (reduced motivation and often poor hygiene) and anhedonia, which is reduced experience of pleasure, often manifesting as scarcity of recreation, inability to experience closeness and reduced interest in any sexual activity.¹

Negative symptoms have been further categorized into primary and secondary symptoms.² Primary (idiopathic) negative symptoms are part of the disorder proper, whereas secondary negative symptoms may have other causes such as medication side-effects, depression or social isolation.

Deficit schizophrenia is an illness subtype in which the patient has primary, persisting negative symptoms.³ This is a subgroup of patients described by specifically defined assessments, and it is not an official classification of symptoms or a diagnostic category.

Negative symptoms have a significant effect on the day-to-day function of patients, affecting their ability to manage the disorder and reducing quality of life. Reduced premorbid adjustment and poorer illness outcome are characteristics of patients with negative symptoms. If a patient is both cognitively impaired and show a lack of emotion, they may be unaware of the true impact of these negative symptoms on their day to day function.¹

Method

We have included only systematic reviews (systematic literature search, detailed methodology with inclusion/exclusion criteria) published in full text, in English, from the year 2000 that report results separately for people with a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder or first episode schizophrenia. Reviews were identified by searching the databases MEDLINE, EMBASE, CINAHL, Current Contents, PsycINFO and the Cochrane library. Hand searching reference lists of identified reviews was also conducted. When multiple copies of reviews were found, only the most recent version was included. Priority is given to reviews with pooled data for inclusion in the Library.

Review reporting assessment was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist which describes a preferred way to present a meta-analysis.⁴ Reviews were assigned a low, medium or high possibility of reporting bias depending on how many items were checked. For instance, a low possibility of bias would be assigned to reviews checking over 66% of items, a medium possibility between 33 and 66% and a high possibility would be given to reviews checking less than 33%. Reviews rated as having less than 50% of items checked have been excluded from the library. The PRISMA flow diagram is a suggested way of providing information about studies included and excluded with reasons for exclusion. Where no flow diagram has been presented by individual reviews, but identified studies have been described in the text, reviews have been checked for this item. Note that early reviews may have been guided by less stringent reporting checklists than the PRISMA, and that some reviews may have been limited by journal guidelines.

Evidence was graded using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group approach where high quality evidence such as
that gained from randomized controlled trials (RCT) may be downgraded to moderate, low or very low if review and study quality is limited, if there is inconsistency in results, indirect comparisons, imprecise or sparse data and high probability of reporting bias. It may also be downgraded if risks associated with the intervention or other matter under review are high. Conversely, low quality evidence such as that gained from observational studies may be upgraded if effect sizes are large, there is a dose dependent response or if results are reasonably consistent, precise and direct with low associated risks (see end of table for an explanation of these terms).\(^5\) The resulting table represents an objective summary of the available evidence, although the conclusions are solely the opinion of staff of the Schizophrenia Research Institute.

### Results

We found six systematic reviews that met our inclusion criteria.\(^1\)\(^3\)\(^6\)\(^8\)

See PRISMA checklists for assessment of reporting transparency.

### Conclusions

- High quality evidence shows a small effect of more severe negative symptoms in patients with a family history of psychosis compared to patients without a family history of psychosis
- High quality evidence shows that the deficit syndrome of schizophrenia is associated with greater severity of negative and, to a lesser extent, greater severity of disorganisation symptoms, lesser severity of mood symptoms and no association with positive symptoms compared to non-deficit schizophrenia. Deficit schizophrenia was also significantly more likely to occur in males than females.
- High quality evidence shows significant concordance of psychomotor poverty symptoms in siblings with schizophrenia. This effect was not replicated in one study of twins with schizophrenia, however.
- Low to moderate quality evidence indicates that negative symptoms occur in 50-90\% of patients at the first episode of psychosis, which decreases to 35-70\% with treatment; 20-40\% of patients have symptoms that persist indefinitely.
- Low to moderate quality evidence suggests negative symptoms may be associated with structural changes in temporal and frontal lobes, and functional changes in frontal and temporal lobes, cerebellum and thalamus.
- Low to moderate quality evidence suggests speech deficits in patients with schizophrenia compared with controls. Large effects were reported for reduced variability of pause time, reduced percentage of time talking, and reduced pause length. Medium effects were reported for reduced number of words spoken, and reduced variability of pitch. Small effects were reported for reduced utterance length, reduced time to initiate speech, reduced number of pauses, and increased variability in volume and intensity.
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Cohen A, Brown LA, Minor KS

The psychiatric symptomatology of deficit schizophrenia: A meta-analysis

Schizophrenia Research 2010; 118: 122-127

View review abstract online

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Magnitude of psychiatric symptoms in deficit syndrome of schizophrenia (identified by either SDS or PDS – see acronyms table) compared to non-deficit schizophrenia patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of evidence</td>
<td>High quality evidence (consistent, precise, direct) suggests deficit syndrome of schizophrenia is associated with greater severity of negative and to a lesser extent with disorganisation symptoms, lesser severity of mood symptoms, and no association with positive symptoms compared to non-deficit schizophrenia</td>
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</table>

### Negative symptoms

*Large effect size suggests significant association of deficit syndrome with greater severity of negative symptoms compared to non-deficit schizophrenia*

†34 studies, N = 1620, $d = 1.01$, 95%CI 0.75 to 1.25, $Q_w = 38.97$, ns

Significant variability of effect size when compared between SDS and PDS assessment, $Q_B = 11.53$, $p < 0.01$. Studies employing the PDS showed only small differences in negative symptom severity between deficit and non-deficit groups, in contrast to SDS which showed a much larger magnitude of difference.

### Disorganisation symptoms

*Small effect size suggests significant association of deficit syndrome with greater severity of disorganisation symptoms compared to non-deficit schizophrenia*

11 studies, N = 1320, $d = 0.29$, 95%CI 0.01 to 0.56, $Q_w = 10.40$, ns

Comparison of SDS and PDS assessment, $Q_B = 1.25$, ns

Patients assessed by the SDS authors showed smaller magnitude of difference in disorganisation than diagnoses by other groups.

### Positive symptoms
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No difference in severity of positive symptoms was reported between deficit and non-deficit schizophrenia

43 studies, N = 2856, $d = -0.17$, 95%CI -0.29 to -0.04, $Q_w = 44.65$, $ns$

Comparison of SDS and PDS assessment (see below for explanation of acronyms), $Q_B = 0.82$, $ns$

Mood symptoms, comprising both subjectively and objectively assessed feelings of anxiety, depression, hostility and guilt

Small effect size suggests less severe mood symptoms in deficit syndrome compared to non-deficit schizophrenia

15 studies, N = 938, $d = -0.34$, 95%CI -0.58 to -0.08, $Q_w = 21.33$, $ns$

Significant variability of effect size when compared between SDS and PDS assessment, $Q_B = 8.17$, $p < 0.05$. Studies employing the SDS showed only small differences in mood symptom severity between deficit and nondeficit groups, in contrast to PDS which showed a much larger magnitude of difference

Overall psychiatric symptoms

No difference in severity of global symptoms was reported between deficit and non-deficit schizophrenia

20 studies, N = 981, $d = 0.15$, 95%CI -0.08 to 0.37, $Q_w = 19.53$, $ns$

Comparison of SDS and PDS assessment, $Q_B = 2.06$, $ns$

Consistency in results‡ Consistent, some differences may be apparent depending on the scale used.

Precision in results§ Precise

Directness of results‖ Direct

Cohen A, Mitchell KR, Elvevag B

What do we really know about blunted vocal affect and alogia? A meta-analysis of objective assessments

Schizophrenia Research 2014; 159: 533-538

View review abstract online

Comparison Speech performance in people with schizophrenia vs. controls
## Summary of evidence

Low to moderate quality evidence (direct, unable to assess consistency or precision) suggests speech deficits in patients with schizophrenia. Large effects were reported for reduced variability of pause time, percentage of time talking, and pause length. Medium effects were reported for reduced number of words spoken, and variability of intonation, and small effects for reduced utterance length, time to initiate speech, and number of pauses. Small effects were reported for increases in variability of speech volume and intensity in patients.

### Speech performance

13 studies overall, N = 806

**Large effects of the following speech deficits in people with schizophrenia compared with controls**
- Variability in pause time: 1 study, $d = -2.56$
- Percentage of time talking: 2 studies, $d = -1.18$
- Average pause length: 4 studies, $d = -1.10$

**Medium effects of the following speech deficits in people with schizophrenia compared with controls**
- Variability of inflection (intonation): 2 studies, $d = -0.70$
- Total number of words spoken: 6 studies, $d = -0.60$
- Number of words spoken per second: 3 studies, $d = -0.49$

**Small effects of the following speech deficits in people with schizophrenia compared with controls**
- Average utterance length: 3 studies, $d = -0.39$
- Variability of volume/intensity: 1 study, $d = 0.33$
- Time to initiate speech: 2 studies, $d = -0.21$
- Total number of pauses: 1 study, $d = -0.20$

### Consistency in results

Unable to assess (consistency measure not reported)

### Precision in results

Unable to assess (CIs not reported)

### Directness of results

Direct

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_Esterberg ML, Trotman HD, Holtzman C, Compton MT, Walker EF_

**The impact of a family history of psychosis on age-at-onset and positive**
### Signs & Symptoms – Negative Symptoms

**and negative symptoms of schizophrenia: A meta-analysis**

**Schizophrenia Research** 2010; 120: 121-130

*View review abstract online*

| Comparison | The impact of a family history of psychosis on severity of negative symptoms of schizophrenia
| Note: see [positive symptoms](#) topic and [age at onset](#) topic for summary pertaining to the impact of family history on these factors |

| Summary of evidence | High quality evidence (large sample, consistent, precise, direct) shows a small effect of more severe negative symptoms in patients with a family history of psychosis compared to patients without a family history of psychosis |

**Positive symptoms**

A small, significant effect suggested that patients with a family history of psychosis showed more severe negative symptoms than patients without a family history of psychosis

12 studies, N = 1172, $d = 0.23$, 95% CI = 0.11 to 0.35, $p$ not reported, $Q_w = 13.05$, $p > 0.05$

Meta-regression revealed a moderate effect: as the proportion of males increased in the group of patients without a family history of psychosis, the mean effect size for the overall difference between groups decreased

$$r = -0.61, p < 0.05$$

| Consistency in results | Consistent |
| Precision in results | Precise |
| Directness of results | Direct |

**Makinen J, Miettunen J, Isohanni M, Koponen H**

**Negative symptoms in schizophrenia: a review**

**Nordic Journal of Psychiatry** 2008; 62(5): 334-341

*View review abstract online*
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<table>
<thead>
<tr>
<th>Comparison</th>
<th>Appearance of negative symptoms in schizophrenia patients. No comparison group defined</th>
</tr>
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<tbody>
<tr>
<td>Summary of evidence</td>
<td>Low to moderate quality evidence (indirect, unable to assess consistency or precision) report negative symptoms occur in 50-90% of patients at the first episode of psychosis, which decreases to 35-70% with treatment; 20-40% of patients have symptoms that persistent permanently. Low to moderate quality evidence (direct, assumed small to moderate samples, unable to assess consistency or precision) suggests negative symptoms were associated with structural changes in temporal and frontal lobes, and functional changes in frontal and temporal lobes, cerebellum and thalamus</td>
</tr>
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</table>

### Prevalence of negative symptoms

Three short term follow-up studies (1-2 years), N not reported, report high prevalence in first-episode psychosis

- At onset, clinically significant symptoms occur in 50-90% of patients
- With treatment, negative symptoms decreased markedly to 35-70% at the end of follow up

In a long-term follow-up study (N, duration not reported), negative symptoms were the most important factor restricting the normal life of schizophrenia patients

### Persistence of negative symptoms

Two long term follow-up studies (N, duration not reported) report 20-40% of schizophrenia patients have permanent negative symptoms after a first episode of psychosis

Two studies (N not reported) suggest prominent negative symptoms are associated with economic, professional, social and functional disabilities. One additional study reports longer hospitalization period, slower recovery and poorer treatment outcomes in patients with more negative symptoms

### Physiological associations with negative symptoms

**Structural imaging**

Two studies (N not reported) used structural magnetic resonance imaging to investigate grey matter volume and reported an association of negative symptoms with reduced volume in the temporal lobe

- Both studies reported grey and white matter loss in the temporal lobe, anterior cingulate, medial frontal cortex compared to healthy controls

Two studies (N not reported) noted particular white matter loss in prefrontal and inferior frontal
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One study (N not reported) reported an association of apathy with reduced bilateral frontal lobe volume, one study (N not reported) reported an association of negative symptoms with reduced size of prosencephalon (forebrain).

Functional imaging

One study (N not reported) showed deficit schizophrenia patients only had N1 event-related potential amplitude reduction and reduced current source density in cingulate and parahippocampal gyri.

Two studies (N not reported) used positron emission tomography and reported an association of negative symptoms with reduced blood flow in right prefrontal area, temporal lobe, cerebellum, and left thalamus, compared with positive symptoms.

Consistency in results
Unable to assess consistency, no measure of heterogeneity reported.

Precision in results
Unable to assess precision, no confidence intervals reported.

Directness of results
No comparison for first two outcomes. Direct for physiological outcome.

Rietkerk T, Boks MPM, Sommer IE, Liddle PF, Ophoff RA, Kahn RS

The genetics and symptom dimensions of schizophrenia: review and meta-analysis

Schizophrenia Research 2008; 102: 197-205

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Comparison
The heritability of psychomotor poverty symptoms, assessed through the concordance of symptoms in twins and siblings with schizophrenia.

Note: psychomotor poverty includes poverty of speech, flat affect and decreased voluntary movement.

Summary of evidence
High quality evidence (direct, consistent, precise) suggests significant concordance of psychomotor poverty symptoms in siblings with schizophrenia. This effect was not replicated in one study of twins with schizophrenia.

Symptom heritability
Measured by OPCRIT
1 study of twins concordant for schizophrenia (N = 57 pairs) suggested no significant heritability association with psychomotor poverty in monozygotic twins ($r = 0.27$) and dizygotic twins ($r = -0.03$).

4 studies compared siblings with schizophrenia, N = 967

A small effect size suggests a significant concordance of psychomotor poverty symptoms between siblings with schizophrenia

$r = 0.17$, 95%CI 0.10 to 0.23, $p < 0.0001$, $I^2 < 0.001$, $p = 0.71$

<table>
<thead>
<tr>
<th>Consistency in results</th>
<th>Consistent for siblings, unable to assess for twin studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precision in results</td>
<td>Precise for siblings, unable to assess for twin studies</td>
</tr>
<tr>
<td>Directness of results</td>
<td>Direct</td>
</tr>
</tbody>
</table>

Roy MA, Maziade M, Labbe A, Merette C

**Male gender is associated with deficit schizophrenia: a meta-analysis**

Schizophrenia Research 2001; 47(2-3): 141-147

[View review abstract online](#)

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Association of male gender in deficit schizophrenia compared to non-deficit schizophrenia subgroups</th>
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<tbody>
<tr>
<td></td>
<td>Note deficit schizophrenia is a descriptive rather than diagnostic term</td>
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| Summary of evidence | Moderate to high quality evidence (consistent, imprecise, large sample size) suggests significant association of deficit schizophrenia subgroups with the male gender. This effect was not moderated by sampling method, diagnosis criteria, or duration of illness |

<table>
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<tr>
<th>Association with gender</th>
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23 studies, N = 1765 consider the association of gender with deficit schizophrenia

The sample contained 28.7% deficit schizophrenia patients

Large effect size suggests significant association of male gender with deficit schizophrenia

$OR = 1.75$, 95%CI 1.39 to 2.21, $p = 0.000002$, $Q_w = 15.87$, $p = 0.82$
**Subgroup analyses**

No effect of sampling method was reported: no significant difference in effect size between convenience and systematic sampling, $Q_B = 0.04$, $p = 0.86$

No effect of deficit assessment method was reported: no significant difference in effect size between three assessment methods:

- Schedule for the Deficit Syndrome (SDS) vs Proxy Deficit Syndrome (PDS), $Q_B = 0.32$, $p = 0.57$
- SDS vs detailed review (DR), $Q_B = 0.85$, $p = 0.36$
- PDS vs. DR, $Q_B = 0.85$, $p = 0.18$

Unlike SDS and DR, the pooled OR for PDS alone did not yield a significant association with male gender, 3 studies, OR = 1.33, 95%CI 0.86 to 2.05

No effect of diagnosis inclusion criteria: no significant difference between schizophrenia or schizoaffective disorder, $Q_B = 0.49$, $p = 0.49$

Pooled OR for schizophrenia alone was significantly different to pooled OR including schizoaffective: OR = 1.68, 95%CI 1.29 to 2.19

No effect of duration of illness: no significant difference between duration less than or greater than 10 years, $Q_B = 1.17$, $p = 0.28$

<table>
<thead>
<tr>
<th>Consistency in results</th>
<th>Consistent, no significant heterogeneity reported</th>
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<tbody>
<tr>
<td>Precision in results</td>
<td>Imprecise</td>
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<tr>
<td>Directness of results</td>
<td>Direct</td>
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**Explanation of acronyms**

CI = Confidence Interval, DR = ‘detailed review’ method for assessing deficit schizophrenia, $I^2$ = the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance), N = number of participants, ns = not statistically significant, OPCRIT = Operational Criteria checklist for psychotic disorders, OR = odds ratio, $p$ = statistical probability of obtaining that result ($p < 0.05$ generally regarded as significant), PDS = Proxy Deficit Syndrome, $Q_B$ = test for between group differences (heterogeneity between groups of studies for an outcome of interest), $Q_w$ = test for within group differences (heterogeneity in study results within a group of studies – measure of study consistency), r = regression coefficient, SDS = Schedule for the Deficit Syndrome, vs = versus
Explanation of technical terms

* Bias has the potential to affect reviews of both RCT and observational studies. Forms of bias include; publication bias - trials which are not formally published tend to show less effect than published trials, further if there are statistically significant differences between groups in a trial, these trial results tend to get published before those of trials without significant differences; language bias – only including English language reports; funding bias - source of funding for the primary research with selective reporting of results within primary studies; outcome variable selection bias; database bias - including reports from some databases and not others; citation bias - preferential citation of authors. Trials can also be subject to bias when evaluators are not blind to treatment condition and selection bias of participants if trial samples are small.†

† Different effect measures are reported by different reviews.

Odds ratio (OR) or relative risk (RR) refers to the probability of a reduction (< 1) or an increase (> 1) in a particular outcome in a treatment group, or a group exposed to a risk factor, relative to the comparison group. For example, a RR of 0.75 translates to a reduction in risk of an outcome of 25% relative to those not receiving the treatment or not exposed to the risk factor. Conversely, a RR of 1.25 translates to an increased risk of 25% relative to those not receiving treatment or not having been exposed to a risk factor. A RR or OR of 1.00 means there is no difference between groups. InOR stands for logarithmic OR where a lnOR of 0 shows no difference between groups. Hazard ratios measure the effect of an explanatory variable on the hazard or risk of an event.

Correlation coefficients (eg, r) indicate the strength of association or relationship between variables. They are an indication of prediction, but do not confirm causality due to possible and often unforeseen confounding variables. An r of 0.10 represents a weak association, 0.25 a medium association and 0.40 and over represents a strong association. Unstandardized (b) regression coefficients indicate the average change in the dependent variable associated with a 1 unit change in the independent variable, statistically controlling for the other independent variables. Standardized regression coefficients represent the change being in units of standard deviations to allow comparison across different scales.

Weighted mean difference scores refer to mean differences between treatment and comparison groups after treatment (or occasionally pre to post treatment) and in a randomized trial there is an assumption that both groups are comparable on this measure prior to treatment. Standardized mean differences are divided by the pooled standard deviation (or the standard deviation of one group when groups are homogenous) which allows results from different scales to be combined and compared. Each study’s mean difference is then given a weighting depending on the size of the sample and the variability in the data. 0.2 represents a small effect, 0.5 a medium effect, and 0.8 and over represents a large effect.†

Prevalence refers to how many existing cases there are at a particular point in time. Incidence refers to how many new cases there are per population in a specified time period. Incidence is usually reported as the number of new cases per 100,000 people per year. Alternatively some studies present the
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number of new cases that have accumulated over several years against a person-years denominator. This denominator is the sum of individual units of time that the persons in the population are at risk of becoming a case. It takes into account the size of the underlying population sample and its age structure over the duration of observation.

Reliability and validity refers to how accurate the instrument is. Sensitivity is the proportion of actual positives which are correctly identified (100% sensitivity = correct identification of all actual positives) and specificity is the proportion of negatives which are correctly identified (100% specificity = not identifying anyone as positive if they are truly not).

\[ I^2 = \left( \frac{Q - df}{Q} \right) \times 100\% \]

§ Imprecision refers to wide confidence intervals indicating a lack of confidence in the effect estimate. Based on GRADE recommendations, a result for continuous data (standardised mean differences, not weighted mean differences) is considered imprecise if the upper or lower confidence limit crosses an effect size of 0.5 in either direction, and for binary and correlation data, an effect size of 0.25. GRADE also recommends downgrading the evidence when sample size is smaller than 300 (for binary data) and 400 (for continuous data), although for some topics, these criteria should be relaxed.

‖ Indirectness of comparison occurs when a comparison of intervention A versus B is not available but A was compared with C and B was compared with C which allows indirect comparisons of the magnitude of effect of A versus B. Indirectness of population, comparator and/or outcome can also occur when the available evidence regarding a particular population, intervention, comparator, or outcome is not available and is therefore inferred from available evidence. These inferred treatment effect sizes are of lower quality than those gained from head-to-head comparisons of A and B.

Thanks to Professor Cherrie Galletly and Professor Vaughan Carr for reviewing the original version of this summary of evidence

Prof. Galletly: Discipline of Psychiatry, the University of Adelaide, Ramsay Health Care Mental Health Services (SA), and Northern Mental Health (AHS)

Prof. Carr: School of Psychiatry, University of New South Wales and the Schizophrenia Research Institute
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References