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Negative symptoms: Barely understood, Poorly treated

The mortality gap between people with a diagnosis of schizophrenia and the general population is widening (Hayes et al., 2017). Negative symptoms form a core dimension of 'Schizophrenia' and remain an unmet clinical need for this population . A recent systematic review found that negative symptoms improved only modestly with psychosocial treatment and that quality of research was 'moderate' at best (Lutgens et al., 2017). In terms of clinically significant outcomes, medical treatments fare no better (Fusar-Poli et al., 2015). In this article, we consider reasons why treatment for negative symptoms is lagging behind treatment for psychosis, and argue that a paradigm shift is necessary to enhance research and knowledge in this area.

A seminal study by van Os and colleagues alerted clinicians and researchers to the dimensional nature of psychosis (van Os et al., 2000). This dimensional approach, however, has not yet been applied to social experience. Instead, categorical divisions are often drawn between social functioning impairments, mood-related difficulties and negative symptoms. There is already mounting evidence directly challenging oft held assumptions about negative symptoms. For instance, studies have shown that anhedonia does not equate to inability to experience pleasure, instead perhaps a reduction in the normative tendency to over-estimate past and future enjoyment (Strauss, 2013). Research into depression and psychosis suggests that disentangling negative symptoms, depression and social functioning is not straightforward as these phenomena are not unrelated. Instead, it is likely that they interact as part of a process contributing to disability, distress and use of services for support (Upthegrove et al., 2017).

A recent review and meta-analysis examining psychosocial treatments for negative symptoms highlighted several major flaws in the existing research (Lutgens et al., 2017). Firstly, the range of treatments offered, from humour therapy to dog-assisted psychological treatment indicated both a lack of consensus and theoretical grounding in existing treatment options. Whilst there may be a theoretical case for some psychological treatments such as CBT, developing and resourcing treatment for negative symptoms without examining and understanding their phenomenology, onset and development is no joke. Another problem highlighted in the review was the over-reliance on 'chronic' populations i.e. those who have experienced multiple episodes of psychosis and long-term disability. This is problematic because long-standing difficulties may be somewhat 'stuck' in this population, making them more resistant to change. In contrast, contemporary research investigating treatment for psychosis draws upon first-episode and 'at-risk' samples, as well as young adult and adolescent populations. Doing so has greatly advanced both understanding and treatment for psychosis as well as challenging stigma and 'us/them' mentalities.

We argue that the main reason that treatment for negative symptoms lags behind that of psychosis is because it continues to be restrained by a biomedical disease framework. This framework is not supported by the evidence - there is compelling research from the broader field of non-clinical psychology which has investigated the same phenomena under the guise of 'social withdrawal' finding evidence for the role of normative interpersonal processes in the development of difficulties (Coplan and Bowker, 2014).

Research into social withdrawal has found that personal and inter-personal factors including, but not limited to, early attachment experiences, adverse peer experiences and trauma influence the development of social withdrawal (Coplan and Bowker, 2014). We argue that, within a dimensional framework, such adverse experiences and styles of coping are likely to play a role in the onset and development of negative symptoms. This remains to be tested in psychosis-specific studies but broadening the scope of negative symptom research with diverse populations will allow this. Research into social withdrawal with young people including adolescents is considered of particular importance because it is acknowledged, even within the broader psychological literature, that this is an under-researched area (Coplan and Bowker, 2014).

In conclusion, we put forward the notion that there needs to be a shift in conceptualisation of negative symptoms, from biomedical dichotomy to continuum of psychological and interpersonal experience. Such a paradigm will lead the way for research with a much broader range of individuals. In turn, this will allow investigation of the underlying processes involved in the development of negative symptoms. Only then, will theoretically informed treatment aimed at improving choice, longevity and quality of life become feasible.

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