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Social functioning in patients with a psychotic disorder and first rank symptoms



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ABSTRACT

There have been suggestions that a sense of self emerges through social interaction, which requires an intact capability to distinguish self from others. Here we investigated the contribution of first rank delusions and hallucinations, i.e. symptom expressions of a disturbed sense of self, to social functioning in patients with a psychotic disorder. Life-time and present-state positive symptom clusters (e.g. first rank delusions and hallucinations) and present-state negative symptoms were submitted to hierarchical multiple-regression analyses with (different domains of) social functioning as dependent variable.

In addition to negative symptoms ($\beta = -0.48$), the life-time presence of first rank delusions is significantly negative associated with level of social functioning, in particular with the quality of interpersonal interactions, with a modest standardized regression coefficient ($\beta = -0.14$).

We reconfirmed the well-established relationship between negative symptoms and social functioning, but the life-time presence of first rank delusions may also have an subtle ongoing effect on the quality of the interaction with others. We propose that the experience of first rank delusions may be an expression of enduring self-disturbances, leaving patients unsure on how to behave in social interactions.

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1. Introduction

In early descriptions of schizophrenia an anomalous sense of self plays an important role in characterizing the disorder (Bleuler, 1911; Mishara et al., 2013). Although disturbed sense of self and its phenomenological and cognitive features have more or less left the research field for several decades, recently they receive more attention. Historically, a sense of self has been described as a

reflective form of self-awareness, emerging through social interaction in “which [...] persons distinguish self from others and thereby relate to others” (p3) (Mishara et al., 2013). In clinical settings, so called first rank symptoms (FRS) may be considered as symptoms of self-disturbance. These symptoms represent auditory hallucinations and delusions of boundary loss between self and others (Heering et al., 2013; Mellor, 1970).

Previously we confirmed a two-factor structure of first rank symptoms, i.e. First Rank Hallucinations (FRH) and First Rank Delusions (FRD) (Heering et al., 2013). FRH are audible thoughts, conversational and commenting voices. Those symptoms are often perceived as intrusive in the normally private mind. FRD represent delusions in which thoughts and actions are believed to be controlled by external forces, e.g. thought insertion, thought withdrawal and delusions of alien control. FRS have lost their value in terms of diagnostic or prognostic value (see for example Norgaard et al., 2008; Crichton, 1996; Ihara, 2009). However, they may help us to understand underlying mechanisms that allow us to distinguish between self and other. For example, patients with FRH, show impairments in self-monitoring (Waters et al., 2012), while patients with FRD experience deficits in tasks assessing body image and body schema (Graham et al., 2014). The ability to distinguish between self and other is a fundamental aspect of a sense of self and for successful social interaction. Also in phenomenological orientated literature, it has been hypothesized that in patients

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Table 1
Symptom clusters according to Heering et al. (2013) (CLUSTER 1–5) and PANSS negative symptoms.

CLUSTER 1 FRD	CLUSTER 2 FRH	CLUSTER 3 Paranoia	CLUSTER 4 Somatic	CLUSTER 5 Grandiosity	Negative PANSS symptoms
Alien control delusion Thought reading	Auditory hallucinations Commenting voices	Persecution delusion Reference delusion	Somatic delusion Somatic/tactile hallucinations Olfactory hallucinations	Grandiosity delusion Religious delusion	Blunted affect Emotional withdrawal
Thought broadcasting Thought insertion Thought withdrawal	Conversational voices			Visual hallucinations	Poor rapport Passive/apathetic social withdrawal Difficulty in abstract thinking Lack of spontaneity and flow of conversation Stereotyped thinking

with FRH and FRD the distinction between self and others may become hazy as a consequence of loss of coherent self (Sass and Parnas, 2003).

Case reports may exemplify the matter further, as in the case of Maria who was “never able to [...] immerse herself in the world because an invisible barrier prevented her full presence” (Cermolacce et al., 2007)(p706) and of Ms D who “struggled to regain her familiar rhythm of conversation and connection with herself and to be able to make contact with others again” (de Vries et al., 2013). Although these disturbances are expected to influence relationships with others, as far as we are aware, there have been no studies directly investigating specific associations between symptoms of self-disturbance, i.e., FRH and FRD, and social functioning. Suggestive evidence for such an association is provided by Haug et al. (2013) who showed high levels of self-disturbance, assessed by means of an extensive structured interview, the *Examination of Anomalous Self-Experience* (EASE) (Parnas et al., 2005) (which includes FRS), to be associated with poor social functioning (Haug et al., 2013).

Earlier research convincingly established the association between more severe negative symptoms and impaired social functioning in patients with a psychotic disorder, (Janssens et al., submitted for publication; Makinen et al., 2008; Milev et al., 2005; Herbener and Harrow, 2004; Lin et al., 2013). In the present study we sought to investigate what the specific contribution of FRH and FRD is on social functioning when taking other positive and negative symptoms into account. Moreover, we sought to investigate whether this association is related to the present-state and/or life-time presence of FRH and FRD symptoms.

2. Methods

2.1. Patient sample

The patients in our study are recruited as part of the Genetic Risk and Outcome of Psychosis (GROUP) study. In this naturalistic follow-up study, 1120 patients with a psychotic disorder, 1057 of their siblings, 919 of their parents, and 590 unrelated control subjects were included. Patients were selected from geographical areas in The Netherlands and Belgium and were identified by representative clinicians whose caseload was screened for inclusion criteria. Subsequently, a group of patients presenting consecutively at these services either as out-patients or in-patients were recruited for the study. In- and exclusion criteria, details on the procedure of recruitment and population characteristics of the GROUP study have been described elsewhere (Korver et al., 2012).

For the current study, we included patients who participated in the first follow-up measurement (i.e., 3 years after baseline measurement). Patients with complete data on the Comprehensive Assessment of Symptoms and History interview (CASH; (Andreasen et al., 1992)) and the Social Functioning Scale (Birchwood et al.,

1990) were included. The CASH was used only at two of the four participating sites, e.g., Amsterdam and Maastricht, leading to a total of 425 patients.

2.2. Measures

2.2.1. First rank and other positive symptoms

The CASH was developed to provide information about the current and past symptoms of psychotic disorders in the affective and schizophrenia spectrum (Andreasen et al., 1992). Here, to assess type and severity of positive psychotic symptoms data from CASH sections 6 and 7 was used. In section 6 the following type of delusions are described: paranoid, jealousy, guilt, grandiosity, religious, somatic, reference, alien body control, thought reading, thought broadcasting, thought insertions and thought withdrawal. CASH section 7 describes auditory hallucinations (including audible thoughts), voices commenting and conversational voices, somatic, tactile, olfactory and visual hallucinations.

The present-state presence of each positive symptom is indicated on a six-point Likert scale from 0 (absent) to 5 (severe), while life-time presence of each positive symptom is indicated as present or not present. In a previous study, we demonstrated that the symptoms described in sections 6 and 7 can be divided in five clusters (Heering et al., 2013), see Table 1 for an overview. The first two clusters include FRD and FRH.

2.2.2. Negative symptoms

Negative symptoms were assessed by means of the negative symptom scale of the Positive and Negative Syndrome Scale (PANSS) (Kay et al., 1987). This scale contains the following items, which are scored based on behavior in the last seven days on a 7-point Likert scale ranging from 1 (absent) to 7 (extreme): blunted affect, emotional withdrawal, poor rapport, passive/apathetic social withdrawal, difficulty in abstract thinking, lack of spontaneity and flow of conversation and stereotyped thinking.

2.2.3. Measure of social functioning

The Social Functioning Scale (SFS) (Birchwood et al., 1990) is a self-report questionnaire designed to evaluate seven areas of functioning essential for community living at a present-state timeframe, and is specifically designed for patients with schizophrenia. The seven subscales are *Withdrawal* (i.e. how much time spend alone), *Interpersonal* (i.e. how comfortable is one in having a conversation with another person), *Independence performance* (i.e. doing grocery shopping by oneself), *Independence competence* (i.e. spending a budget rightfully), *Recreation* (i.e. exercising a hobby), *Pro-social* (i.e. going to a party) and *Employment* (i.e. having a part-time job). The total score of the SFS is calculated as the mean of the seven subscales and higher scores reflect better social functioning.

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