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Ten-year stability of self-reported schizotypal personality features in patients with psychosis and their healthy siblings

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ABSTRACT

Schizotypal personality disorder (SPD) symptoms or features are common in patients with psychosis and their healthy relatives. However, the long-term stability of these SPD features and therefore their constituting enduring traits underlying vulnerability to psychosis remain to be clarified. Thirty-two patients with psychotic disorders and 29 of their healthy siblings were included from the long-term follow-up study of 89 nuclear families. Participants were clinically assessed by means of a semi-structured diagnostic interview, whereas the Schizotypal Personality Questionnaire-Brief (SPQ-B) was applied for the self-assessment of SPD symptoms. The assessments were carried out upon admission to the study and at follow-up, about 10 years later. The patients had higher scores than their siblings on the SPQ-B both at baseline and follow-up. In addition, self-reported SPD symptoms remained stable over time in total scores and in all the SPQ-B subscores, except for the SPQ-B Disorganization subscale. Self-reported SPD symptoms were stable over the long term among patients with psychotic disorders and their healthy siblings. This finding provides new support for including the SPD construct as a trait measure for studies addressing both vulnerability to psychosis in first-degree relatives of patients with psychosis and long-term persistence of symptoms in patients suffering from psychosis.

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1. Introduction

The finding of prevalent psychotic-like experiences in the general population seems to support the validity of the continuum hypothesis of psychosis (Fonseca-Pedrero et al., 2009; Nelson and Yung, 2009). On the other hand, the concept of schizotypal personality structure, originally stemmed from the classic framework of schizotaxia and schizotypy (Meehl, 1989; Rado, 1953), and later incorporated as a personality disorder in contemporary psychiatric taxonomy, rather appears to corroborate the hypothesis of a distinctive psychopathological deviation from healthy conditions in first-lifetime emerging psychosis. In addition, Meehl's schizotaxia–schizotypy model paved the way to the conceptualization of "psychosis proneness" by Chapman and Chapman (1985). Despite the fact that schizotypy has been considered taxonic in North American tradition, the European view has mainly favored a fully dimensional approach to this construct (Kwapil and Barrantes-Vidal, 2012). Therefore, while schizotypy has come to imply a multidimensional neurodevelopmental and psychopathological vulnerability to schizophrenia, schizotypal personality disorder reflects a nosological category of an Axis II diagnosis within the schizophrenia spectrum disorders (Kwapil and Barrantes-Vidal, 2012). Assuming that schizotypal personality disorder might represent not only a categorical diagnostic realm but also a key multidimensional psychopathological construct, schizotypal personality features may be potential vulnerability indicators for schizophrenia and psychosis (Horan et al., 2008). In this regard, several studies have provided interesting data on schizotypal phenomenology complex relationship with psychosis. Schizotypal personality disorder features have been associated with the risk of developing schizophrenia (Compton et al., 2009; Miller et al., 2002), as well as with neurocognitive and psychosocial impairment in schizophrenia patients (Compton et al., 2009; Gooding et al., 2006), and schizotypal personality disorder symptoms have been found to be more common in relatives of patients with psychosis (Compton et al., 2009; Kendler et al., 1995).

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Following Nuechterlein and Dawson (1984) a valid and reliable candidate indicator of vulnerability to psychotic disorders should show evidence of a clear abnormality as compared to the general population, and that the abnormality itself be an enduring feature regardless of patients clinical status. In addition, the pattern of variation in severity of the abnormality in relation to the level of variation in symptoms over the course of the psychotic illness is essential to differentiate between stable, mediating and episode-related vulnerability markers (independent, partially dependent and dependent on the acute symptomatology, respectively) (Horan et al., 2008).

In addition, a significant number of self-report rating scales have been developed to define the concept of schizotypal personality structure with a purely dimensional approach including the Physical and Social Anhedonia Scales (Chapman et al., 1976), the Perceptual Aberration Scale (Chapman et al., 1978) and the Magical Ideation Scale (Eckblad and Chapman, 1983), among others (Compton et al., 2007). However, the use of these scales may have some drawbacks such as their length and the fact that they do not represent the nine features of SPD described in DSM-III-R (Raine, 1991) while exploring the classic psychopathological construct of schizotypy and schizotaxic-derived vulnerability to schizophrenia. To solve the latter limitation, Raine developed the Schizotypal Personality Questionnaire (SPQ), a 74-item self-report instrument, based on DSM-III-R criteria for Schizotypal personality disorder (SPD) and including nine subscales to evaluate the nine features of SPD listed in DSM-III-R (Raine, 1991; Raine and Benishay, 1995). This questionnaire has shown to have a three-factor structure, namely Cognitive-Perceptual Deficits (Ideas of Reference, Magical Thinking, Unusual Perceptual Experiences and Paranoid Ideation), Interpersonal Deficits (Social Anxiety, No Close Friends, Blunted Affect, Paranoid Ideation), and Disorganization (Odd Behavior, Odd Speech) (Axelrod et al., 2001). A confirmatory factor analysis of the nine subscales demonstrated that these three factors best represent schizotypal personality construct, and seem to be equivalent to the three factors (positive, negative and disorganized) that have been identified for schizophrenic symptomatology (Arndt et al., 1991; Raine and Benishay, 1995). Despite there is a consensus in that schizotypy is a multidimensional construct and that the Raine's three-factor model is the most replicated, not all studies confirmed it and there are other studies supporting a four-factor model in the SPQ (Fonseca-Pedrero et al., 2014; Stefanis et al., 2004) as well as a five-factor model at an item-level of the SPQ in a large sample of undergraduate students (Chmielewski and Watson, 2008).

Furthermore, Raine and Benishay (1995) developed a shorter instrument, the Schizotypal Personality Questionnaire-Brief (SPQ-B) that may be used when the time for evaluation is limited or to screen a large number of individuals for predisposition to SPD. This is a self-report scale, based on the SPQ, containing 22 items and subscales for the same three factors. It has a good criterion validity (mean $r=0.62$) and the internal and test–retest reliability appear to be reasonable ($r=0.72$–0.95) (Raine and Benishay, 1995). The dimensional structure of the SPQ-B has been addressed in different studies in non-clinical populations reporting different solutions ranging from two (Aycicegi et al., 2005), and three (Axelrod et al., 2001; Compton et al., 2007, 2009; Mata et al., 2005) to four factors (Cohen et al., 2010; Fonseca-Pedrero et al., 2010).

Despite the SPQ-B is widely used to identify schizotypy that hypothetically may increase the vulnerability to schizophrenia in non-patient individuals, little is known about whether patients with psychosis show either stable or changing scores on these scales across different clinical states. This approach has been used with the Chapman's and colleagues Psychosis Proneness Scales to clarify the extent to which their psychometric vulnerability indicators (positive and negative schizotypy) represent state or trait phenomena (Horan et al., 2008).

Moreover, there are few studies on schizotypal personality symptoms that include patients with schizophrenia. Vollema and Postma (2002) found support for the positive dimension of the SPQ as a vulnerability marker of the disease by examining schizophrenia patients, siblings of schizophrenia probands and healthy controls. Also, Horan et al. (2008) examined the longitudinal patterns of the Chapman's and colleagues scales in recent-onset schizophrenia patients to test specifically their changes over time and across clinical states.

As positive and negative symptoms vary diachronically from the acute episode to the remission state, and providing that schizotypal symptoms are defined on the basis of diminished forms of the symptoms of psychosis, it could be relevant to evaluate whether these self-reported schizotypal symptoms are stable over time from the acute episodes throughout long-term follow-up phases.

To the best of our knowledge, the stability of SPD features over time has been explored in a few studies (Ericson et al., 2011; Meyer and Hautzinger, 1999; Squires-Wheeler et al., 1991) and never evaluated using SPQ-B. The aim of the current study was to evaluate the SPQ-B stability in a sample of patients with psychotic disorders and their healthy siblings over 10 years of follow-up.

We hypothesized that patients with psychosis would have higher scores than their healthy siblings on the SPQ-B and that, based on SPD being an enduring trait, scores would remain stable over time in both groups.

2. Methods

2.1. Participants

The initial sample population included 89 nuclear families recruited in Virgen del Camino Hospital in Pamplona, Spain. These nuclear families comprised one member with a psychotic disorder, who was recruited from consecutive admissions to the Acute Psychiatric Unit for psychotic exacerbations, between 1999 and 2001, one healthy sibling and both parents. Patients underwent a comprehensive evaluation using a semi-structured diagnostic interview (The Comprehensive Assessment of Symptoms and History, CASH) (Andreasen, 1992). The CASH interview includes the positive and negative symptoms rating scales, and in this study was combined with other instruments for the assessment of motor and psychopathological dimensions and cognitive phenomena, as described in detail elsewhere (Rosa et al., 2004). Parents and healthy siblings of patients were screened using an abbreviated version of the CASH to evaluate and rule out a history of psychiatric disorders in proband's parents and siblings respectively.

For this study, we included only those patients and their siblings who agreed to undergo a second evaluation in 2009. This sample comprised 42 patients and 35 of their siblings (43% of the initial sample). Reasons for discontinuation of participants included death (8 pairs; 7 patients and 1 sibling), traumatic brain injury (1 patient), change of residence and failure to contact them (11 pairs), and declining to participate to the follow-up assessments (27 patients and 34 siblings).

For the present research report, we analyzed data gathered from 32 patients and 29 of their siblings, who completed the clinical assessments required for this study including SPQ-B at baseline and follow-up. The average time between initial and final evaluation was 9 years and 6 months (range: 7–11 years).

Demographic data and diagnostic categorization of study subjects are shown in Table 1. All patients suffered from a psychotic episode and they did not fulfill Schizotypal personality disorder diagnostic criteria. Those patients with a mood disorder diagnosis ($n=4$) had mood-incongruent psychotic affective symptoms.

All subjects gave written informed consent to participation in the research project and the study protocol was approved by the local ethics committee.

2.2. Procedures

Participants were evaluated using the Schizotypal Personality Questionnaire-Brief (SPQ-B) (Raine and Benishay, 1995) at baseline and at 10-year follow-up. As we mentioned previously, SPQ-B is a brief, 22-item self-report screening instrument, its estimated administration time being only 2 min. This questionnaire is based on the SPQ and results are a total scale score and scores for three subscales (Cognitive-Perceptual Deficits, Interpersonal Deficits, and Disorganization). We used a Spanish version that has previously been validated in adolescents (Fonseca-Pedrero et al., 2010, 2009).

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