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Unraveling the Overlapping Negative and Cognitive Symptoms in Schizophrenia

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Harvey:
This is CME on ReachMD, and I'm Dr. Philip Harvey. Here with me today is Dr. Martin Strassnig.

Martin, can you help our listeners differentiate between negative and cognitive symptoms in schizophrenia? This is an area where there's a considerable amount of confusion and misunderstanding, and I think some clarification about what is cognitive and what is negative and what the implications of those would be really helpful.

Dr. Strassnig:
Yeah, sure. Now let me also include, you know, for the sake of completeness, positive symptoms because you really have to think about the triad of positive, negative, and cognitive symptoms in order to understand the impact of schizophrenia most comprehensively. Right? So positive symptoms are hallucinations, delusions. Those are usually easily detected and, coincidentally, relatively easily treated. However, the second part of this triad are negative symptoms, and those are a little harder to understand usually. They primarily involve something that's not there, that is a reduction or loss of normal function. Affective or emotional flattening; reduced motivation; reduced social interactions, that is withdrawal; lack of speech, alogia we call it; and then motivation, as I mentioned. So there is withdrawal, basically, associated with negative symptoms or something that is, quote/unquote, not there. And then there are cognitive impairments which involve problems with processing of information, memory, attention, and executive function, right? And those taken together impact the ability to perform tasks and solve problems, basically. And we may have mentioned that before, that the cognitive symptoms really provide a bottleneck towards outcome.

Now, interestingly enough, there is some interaction between negative and cognitive symptoms in terms of how they affect everyday activities. Right? So you can't just throw them into the same pot and treat them as the same; they're distinctly different symptom clusters. For example, we found out that negative symptoms predict social outcomes more so than vocational functioning or everyday activities. And quite to the contrary, cognition predicts vocational functioning and everyday activities but not social outcomes. So in the end, it becomes crucial to ask yourself, what are you actually trying to treat or ameliorate, right?

And so it becomes a matter of specificity. What do you want to do, right? Treatment aimed at cognition may not affect social functioning, for example, as much as other aspects of disability, like vocational functioning or everyday activities, getting out of the house, getting a job. Whereas negative symptoms predominantly seem to load on social functioning, interpersonal abilities, if you will.

And I don't know, Phil, whether you have anything to add here.

Dr. Harvey:
Yeah. I think it's important to mention that negative symptoms have a couple of different subdomains. One is reduced emotional

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experience, which is the motivational substrate that you were talking about that interferes with people's interest in doing things they can do. And the other is the reduced emotional expression. Blunted affect is a very striking symptom. A lot of patients speak with real monotone voices, and interestingly enough, it turns out that reduced emotional experience, avolition, amotivation, are more strongly related to poor outcomes than reduced emotional expression. So although flat affect is striking, it may not be as disabling as amotivation, which interferes with people doing things that they have the capability to do. So that's the interface between negative and cognitive symptoms. Negative symptoms can sometimes impede the interest in performing tasks that we know you can accomplish, even if your cognitive impairment is not that substantial.

So this has been a great bite-sized discussion. Hopefully you can put some of these tips into your own practice tomorrow, and thanks very much for listening.

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