Assessment of Negative Symptoms: 
Instruments and Evaluation Criteria

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Introduction

Interest in negative symptoms has increased in recent years (cf. Strauss 1985; Pogue-Geile and Zubin 1988), as evidenced by a great number of theoretical as well as empirical papers dealing either with the investigation of negative symptoms or applying them as moderator variables in researching various questions.

This interest in negative symptoms and their differentiation from positive ones is connected in particular with the hope of identifying factors with different prognostic, therapeutic and pathogenetic significance (Crow 1989). Research involves prediction of the course of illness (particularly long-term; Pogue-Geile and Harrow 1985; Strauss et al. 1989: psychological and social influence of negative symptoms on the course) and the response to therapy (Andreasen 1982). Particularly fascinating are the aetiological questions (cf. also Zubin 1985) in the sense of covariation with structural brain changes, neurochemical, neurophysiological or genetic features (Crow 1985).

Origins of the concept can already be found in the nineteenth century (Berrios 1985), although no uniform theory is discernable up to the present time (Sass 1989). The definitions are broad to varying extents (Crow 1985) and are, thus, also associated in part with a number of other concepts or are even uses synonymously with them (e.g. acute vs. chronic, plus vs. minus; cf. Sass 1989). In the latter case, however, specific implications are usually additionally connected to them (e.g. residual symptoms: chronicity, course, onset and domain of function; Sommers 1985).

Many definitions of negative symptoms share the absence of or the inadequate development of normal functions (e.g. Sommers 1985; Grossman et al. 1989; Zubin 1985). According to Lenzenweger et al. (1989, p. 62), one can differentiate between positive and negative symptoms as follows:

- Positive symptoms: presence of a behaviour or function that is otherwise normally not present in an individual.
- Negative symptoms: absence of a behaviour or function that is usually present in the normal individual.

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Here, deficits are postulated in very different areas: cognitive, social and affective (e.g. Kay and Opler 1987; Sommers 1985).

It is generally acknowledged that when referring to negative symptoms, we are dealing with significant characteristics of the schizophrenic syndrome (Andreasen 1982). This can be concluded, for example, from the various diagnostic systems (Berner et al. 1983), although the symptoms in question are not specific to schizophrenia (Mundt et al. 1989). Other nosological groups, in particular groups of depressive patients (e.g. Stieglitz and Helmchen 1990), can also exhibit these characteristics. Thus, according to Alpert (1985), the characteristic “flat affect” can be an aspect of retardation in depressive patients, an expression of neuroleptic side-effects or a schizophrenic characteristic within the context of diagnostic systems (e.g. Diagnostic and Statistical Manual, DSM-III-R). Furthermore, negative symptoms can occur in all stages of the course of schizophrenia (Angst et al. 1989: prepsychotic, productive psychotic or post-psychotic period).

One of the basic problems includes establishing and specifying which symptoms are to be classified as negative and clearly delimiting these from the positive symptoms (Grossman et al. 1989). Moreover, there is a controversial discussion in progress regarding the extent to which a number of negative symptoms are primary or secondary (cf. e.g. Carpenter et al. 1985). Thus, for example, the frequently cited symptom of social withdrawal can be interpreted as a reaction to positive symptoms (e.g. delusions), as a consequence of the illness (Crow 1989) or as coping with the symptoms or the illness. In addition, negative symptoms are connected with a number of other characteristics of the illness, such as, for example, intellectual impairment and neurological signs (Crow 1989).

In spite of great differences in how broadly these concepts are defined (and their operationalisation by means of assessment instruments), there is a focal group of characteristics (flat affect and poverty of speech, among others), which are included in most operational definitions.

Negative symptoms range from features which are relatively easy to comprehend and define all the way to highly complex, psychopathological concepts (Rösler and Hengesch 1990).

The increasing interest in negative symptoms and their distinction from other psychopathological areas has led a number of researchers to develop assessment instruments (Grossman et al. 1989). In the more recently developed scales, one tends to find that the concept of negative symptoms is formulated more broadly.

The application of different assessment instruments is one reason for the partly discrepant results found in the literature concerning negative symptomatology (cf. e.g. Pogue-Geile 1989; Thiemann et al. 1987), for example:
- General methodological limitations (e.g. static rather than dynamic point of view; Kay and Opler 1987).
- Variesly broad concepts of schizophrenia (e.g. Pogue-Geile 1989).
- Composition of the samples (e.g. different degrees of chronicity; Pogue-Geile 1989).