

Reliability and validity of the Self-Report Version of the Apathy Evaluation Scale in First-Episode Psychosis: Concordance with the Clinical Version at Baseline and 12 Months Follow-up

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ABSTRACT

Negative symptoms have traditionally been assessed based on clinicians' observations. The subjective experience of negative symptoms in people with psychosis may bring new insight. The Apathy Evaluation Scale (AES) is commonly used to study apathy in psychosis and has corresponding self-rated (AES-S) and clinician-rated (AES-C) versions. The aim of the present study was to determine the validity and reliability of the AES-S by investigating its concordance with the AES-C. Eighty-four first-episode (FEP) patients completed the shortened 12-item AES-S and AES-C at baseline (T1) and 12 months (T2). Concordance was studied by degree of correlation, comparison of mean scores, and change and difference between diagnostic groups. The Positive and Negative Symptom Scale (PANSS) was used to study convergent and discriminative properties. High concordance was found between AES-S and AES-C at both T1 and T2 regarding mean values, change from T1 to T2, and the proportion with high levels of apathy. Both versions indicated high levels of apathy in FEP, while associations with PANSS negative symptoms were weaker for AES-S than AES-C. Controlling for depression did not significantly alter results. We concluded that self-rated apathy in FEP patients is in concordance with clinician ratings, but in need of further study.

Key words: psychosis; negative symptoms; apathy; amotivation; self-report; clinician-rating

1. Introduction

Understanding negative symptoms is a major challenge in schizophrenia research and treatment (Kirkpatrick et al., 2006; Montgomery and van Zwieten-Boot, 2007; Marder and Galderisi, 2017). Methodological improvements of assessments may help research, and one possible solution could be to include self-reports. However, nearly all studies of negative symptoms have relied on assessments made by observers; relatively few have evaluated the subjective experience of people with psychosis (Selten et al., 1993; Park et al., 2012; Llerena et al., 2013; Engel and Lincoln, 2016; Dollfus et al., 2016). The contents of the negative syndrome in psychotic disorders consist of the five subdomains of apathy/avolition, anhedonia, asociality, alogia and affective flattening (Kaiser et al., 2017), which cluster into the two separate factors of 1) amotivation/apathy and 2) expressive deficit (Marder & Galderisi, 2017). Apathy and anhedonia are internal experiences and, therefore, more accessible and suitable for self-reporting than observation-based expressive deficits (Andreasen N.C., 1990; Marder & Galderisi, 2017).

Apathy is common in psychotic disorders and has been found to be a strong contributor to a poor outcome from the first episode throughout the course of the illness (Kiang et al., 2001; Roth et al., 2004; Faerden et al., 2010; Evensen et al., 2012; Fervaha et al., 2015). Marin et al. defines apathy as a “lack of motivation and goal directed behavior” (Marin, 1991). This definition is the conceptual basis for the Apathy Evaluation Scale (AES) (Marin et al., 1991), which, in addition to psychosis, has been used to study apathy across a number of different disorders, including Parkinson’s disease, multiple sclerosis, Alzheimer’s, and stroke (Andersson S. et al., 1999; Lueken et al., 2007; Sagen, U. et al., 2010b; Santangelo et al., 2014; Raimo et al., 2014). The AES is found to have sound psychometric qualities (Weiser and Garibaldi, 2015; Radakovic et al., 2015) and exists in two otherwise identical versions, a clinician-rated AES-C and a self-report AES-S (Marin et al., 1991). The existence of two modes of reporting can provide insight into the subjective experience of apathy in people with psychosis and their relationship to external observations.

Self-reports can be developed through direct involvement with the target group (Rose et al., 2011; Evans et al., 2012; Dollfus et al., 2016) or by adjusting an established observer-based scale (Park et al., 2012). Only minor adjustments were made when a self-report version of the Clinical Assessment Interview for Negative Symptoms (CAINS) (Blanchard et al., 2011), the CAINS-SR, was used (Park et al., 2012; Llerena et al., 2013; Engel & Lincoln, 2016). However, of the two subscales making up the CAINS, only the subscale Motivation and Pleasure (i.e., apathy/anhedonia) was found to have a satisfactory concurrent validity with the clinician-rated measure of the same domain and not the expression subscale (Park et al., 2012). The AES-S is also developed as an adaptation of the existing clinician-rated scale

(Marin et al., 1991). To our knowledge, the AES-S has only been used in one former study of persons with psychosis (Evensen et al., 2012), yet how the self-report relates to the clinicians' assessments remains to be investigated. Since self-reports are easier to use for screening purposes, it is of interest to see if the AES-S can be used to screen for high levels of apathy.

The AES-C has shown good psychometric properties in people with psychosis, both in first-episode patients (Faerden et al., 2008) and in patients with longer durations of illness (Kiang et al., 2001). As expected, the AES-C shows strong associations with measures of negative symptoms made by traditional rating scales (Kiang et al., 2001; Faerden et al., 2010; Foussias et al., 2011; Konstantakopoulos et al., 2011). We have previously reported that 50% of first-episode psychosis (FEP) patients have high levels of apathy at the start of treatment as measured by the AES-C, with even higher levels of apathy in patients diagnosed within the narrow schizophrenia spectrum (Faerden et al., 2010). Levels of apathy in both groups of patients were more strongly associated with concurrent poor functioning (Faerden et al., 2010) and also better predicted future poor functioning in a 1-year follow-up of the same study sample (Faerden et al., 2013).

Negative symptoms are traditionally divided into primary and secondary symptoms, where the primary are thought to be related to neurobiological underpinnings, and the secondary are influenced by other sources of negative symptom-like features, such as depression, positive symptoms, and medication side effects (Kirschner et al., 2017). Apathy and depression have overlapping clinical features, including reduced initiative and lack of energy, which makes differentiation a challenge (Marin et al., 1993). The original definition states that the apathetic features should not be "due to emotional distress" to avoid a potential overlap with depression (Marin et al., 1991). However, because depression is a common feature in FEP (Romm et al., 2010), this criterion is often not applicable. Three of the four recently published studies of self-reports of negative symptoms found a significant association between negative symptoms and depression (Park et al., 2012; Engel & Lincoln, 2016; Dollfus et al., 2016), with the only exception a study by Llerena et al. (2013). Therefore, it is important to explore how both depression and other contributors to secondary negative symptoms, such as positive symptoms, may influence self-reports of apathy in FEP (Kirschner et al., 2017). Finally, patients' self-reports can differ from the evaluation of others because of a lack of insight into the illness and its consequences, and the effect of insight should thus be accounted for.

The aim of this study was to assess the concordance of the psychometric, convergent, and discriminative properties of the AES-S in FEP patients by comparing the AES-S and the

AES-C. This was accomplished by investigating the following at both baseline and at 1-year follow-up: 1) Does the AES-S have the same psychometric properties as the AES-C? 2) Is there concordance in mean apathy scores, changes over time, and differences between diagnostic groups? 3) What are the convergent and discriminative properties in relation to the different PANSS symptom factors, and to what extent do depression, positive symptoms, and lack of insight influence the association to PANSS negative symptoms? 4) Can the AES-S be used to screen for high levels of apathy that is in concordance with the AES-C?

2. Methods

2.1 Participants

The present study included 84 FEP patients who completed both the AES-S and the AES-C at baseline and at 1-year follow-up. All participants are part of the ongoing Thematically Organized Psychosis (TOP) study in Oslo, Norway, consecutively recruited from specialized inpatient and outpatient psychiatric health services serving three out of six catchment areas in Oslo. Inclusion took place between July 2004 and June 2006, and participants met the following criteria: age between 18 and 65 years, a first episode of psychosis, and a DSM-IV diagnosis of schizophrenia, schizophreniform disorder, or schizoaffective disorder (constituting Group 1: Schizophrenia spectrum disorders); affective disorder with mood incongruent psychotic symptoms or bipolar I disorder (constituting Group 2: Affective psychotic disorders); and psychosis not otherwise specified, delusional disorder, or brief psychotic disorder (constituting Group 3: Other psychotic disorders). Patients were eligible for inclusion in the study up to 1 year following the start of first treatment.

This study includes the 84 participants who completed the AES-S and AES-C at both baseline and at the 1-year follow-up. A total of 124 took part in the 1-year follow up, but 40 of these were eliminated from the current study due to incomplete assessments by the AES-S or the AES-C, totaling this study to 84. There were no significant differences between the 124 participants and the 84 including the analyses regarding gender, age, level of education, duration of untreated psychosis (DUP), PANSS symptoms, or diagnostic distribution.

2.2 Assessment

The first assessment was carried out as close to first treatment contact as inclusion allowed for (T1) and repeated after 12 months (T2). Diagnostic assessment was carried out using the Structural Clinical Interview for DSM-IV (SCID-I). The duration of untreated psychosis (DUP) was measured from the first week that psychotic symptoms appeared, defined as having a score of ≥ 4 on the Positive and Negative Syndrome Scale (PANSS) (Kay SR and Fiszbein A, 1987) items P1, P3, P5, P6, or G9 until the first week of adequate antipsychotic medication.

Psychosocial functioning was assessed with the functioning score of the split version of the Global Assessment of Functioning Scale (GAF-F) (Pedersen et al., 2007). The GAF-F is scored between 0 and 100; a low score indicates worse functioning in independent living, degree of social relations, and ability to work.

Positive, negative, and general symptoms were assessed using the Structural Clinical Interview of the PANSS (SCI-PANSS). As in in the previous validation study of the AES-C, we used Emsley's five factor model of PANSS (Emsley et al., 2003) to establish convergent and discriminate validity to positive, negative, disorganized, depressive, and excitatory symptoms. In this five factor model of PANSS, the positive factor is represented by items P1, P2, P5, P6, G9, and G12; the PANSS negative factor is represented by N1, N2, N3, N4, N6, G7, G13, and G16; the PANSS disorganized factor is represented by P2, N5, N7, G5, G10, G11, and G15; the PANSS depressive factor by G1, G2, G3, G4, and G6; and the PANSS excited factor by P4, P7, G8, and G14. For convergent and discriminative validity of the two negative factors, amotivation and expressive deficits, we used the model proposed by Liemburg (Liemburg et al., 2013) and established the PANSS amotivation factor, which consisted of items N2, N4, and G16 and the PANSS expressive deficits factor, which consisted of N1, N3, N6, G5, G7, and G13. Depression was assessed with the Calgary Depression Scale for Schizophrenia (CDSS).

Apathy was assessed both with the AES-S and the AES-C. Each form takes from 10–20 minutes to complete and consists of identical questions only reframed from “Does she/he” to “Do you”. Each item is scored on a 4-point Likert scale, ranging from 1 (not at all characteristic of me) to 4 (very characteristic); higher scores indicate apathy. The questions focus on the degree of self-experienced motivation and interests during the last 4 weeks and do not include measures of functioning. A general instruction for scoring is indicated in both scales, but the AES-C has instructions for ratings that probe level of interest in activities and affective tone. We have previously shown that a shortened 12-item scale is a better measure of apathy in a FEP population than the full 18-item version (Faerden et al., 2008). This study

also uses a shortened AES-S, taking out the same six items as in the shortened AES-C; the latter of which is used as the “gold standard.”

2.3 Procedures

All participants provided written informed consent to participate. The study was approved by the Regional Committee for Medical Research Ethics and the Norwegian Data Inspectorate in 2004. The data file received an Audit Certificate from the Center for Clinical Research at Oslo University Hospital in 2007.

The FEP participants filled in the AES-S form with no interference from the observer, except if clarification was needed. The AES-C interviews took place after the patients had filled out the AES-S.

The three investigators in the current study completed the structured assessment training and reliability program of the TOP study. For DSM-IV diagnostics, raters trained in reliability in the use of the Structural Clinical Interview for the DSM-IV (SCID-I) carried out the assessments. The mean overall kappa for the standard diagnosis of training videos was 0.77, and the mean overall kappa for a randomly drawn subset of actual study patients was 0.77 (95% CI 0.60–0.94). Inter-rater reliability (Intra Class Coefficient (ICC) 1.1) for the PANSS positive subscale was 0.82 (95% CI 0.66–0.94), for the PANSS negative subscale 0.76 (95% CI 0.58–0.93), the AES-C 0.98 (95% CI 0.92–0.99), and the GAF-F 0.85 (95% CI 0.76–0.92).

2.4 Statistics

The statistical analyses were conducted using SPSS version 22. Preliminary analyses were performed to examine the distribution of each variable. Due to extremely skewed data distribution, the DUP underwent logarithmic transformation to its natural logarithm (ln). All analyses were performed at T1 and T2. All analyses were two-tailed with a predefined level of significance of $< .05$. Because we focused on patterns of associations and degree of significance for the two forms of the scale and not on group differences *per se*, we did not correct for multiple testing.

Descriptive data are presented either by means and standard deviations or median and range. Differences between groups were analyzed using independent t-tests or dependent samples t-test for in-between group's analyses and with one-way analyses of variance ANOVA for more than two groups with the Tukey HSD post hoc test.

Since this current study compares the 12-item version of the AES-C to the AES-S, we test the homogeneity of the 12-item AES-S by reporting the item-total correlation. Reliability of the 12-item AES-S was examined by calculating the internal consistency using Cronbach's alfa (α) coefficient, which ranges from 0 to 1, with a value $\geq .7$ considered as acceptable.

Strength of relationships between variables was assessed using Pearson's correlation coefficient (r) for the study of concordance, convergent, and discriminate validity. Degree of correlation was defined according to Cohen, where $r < .3$ is weak, $r = .3 - .5$ is moderate, and $r > .5$ is strong (Cohen J., 1988). Shared variance was estimated by the square value of r and converted to percentage variance by multiplying by 100.

Concordance between the AES-S and the AES-C was examined by degree of bivariate correlation, comparing mean values, changes in scores, and differences in mean values between diagnostic groups. External convergence were examined between the AES-S and the two PANSS negative factors: PANSS amotivation and PANSS expressive deficits factor, and the seven PANSS negative items. Discriminate validity was examined to the other four PANSS symptoms factors of positive, disorganized, depressive and excitative. We hypothesized to find the the strongest correlation to the PANSS amotivation factor and PANSS items N2 and N4, in line with the previous study of the AES-C (Faerden et al., 2008) and with a moderate correlation to the PANSS depressive factor and weak or nonsignificant to other PANSS symptom factors.

To control for emotional distress and to be in accordance with Marin's definition of apathy (Marin et al., 1991), we did partial correlation analyses, controlling for depression. We also controlled for other possible secondary sources e.g. positive symptoms and (lack of) insight. To control for depression, we used the CDSS; for positive symptoms, we used the PANSS positive factor as defined above; and for insight, we used PANSS item G12 (Lack of judgment and insight). We expected that the results would not be significantly altered. Differences in strength of correlations were determined by Fisher's Z transformation of r , according to Cohen (Cohen J., 1988)

A cut-off score of ≥ 27 , based on the mean value $\pm 2SD$ found in a healthy comparison group, has been used in previous studies with the AES-C to discriminate between high and low levels of apathy (Faerden et al., 2008). With this cut-off value, we used receiver operating characteristic (ROC) analysis and measured area under the curve (AUC) to study if the AES-S could accurately discriminate between high and low levels of apathy as assessed with the AES-C. An AUC of 1 is considered a perfect test, .80 – .90 good, .70 – .80 fair, .60 – .70 poor, and .50 – .60 worthless. We calculated sensitivity and specificity with the AES-C using cross tabs calculations.

3. Results

3.1 Sociodemographic and clinical characteristics

Table 1 displays the sociodemographic and clinical characteristics of the 84 participants. There was a significant decrease in the levels of all symptoms with the exception of the PANSS negative symptoms, and there was a significant increase in functioning from T1 to T2.

3.2 Internal consistency

Cronbach's alpha (α) for the AES-S was .87 at T1 and .90 at T2. The same high internal consistency was found for the AES-C with $\alpha = .91$ at T1 and $\alpha = .89$ at T2. Table 2 displays the mean score and item-total correlation for the 12 items of the shortened AES-S used in this study. All items had an item-total correlation above .3 (Table 2) except for item 10 (Someone has to tell her/him what to do each day) with an item-total correlation at T1 of .15 and at T2 of .22. Removing this item altered the Cronbach's α at T1 to .89 and at T2 to .91, which is a minimal change.

3.3 Concordance between the AES-S and the AES-C in mean total apathy score, change, and differences between diagnostic groups

The correlation between the AES-S and the AES-C was $r = .64$ at T1 and $r = .61$ at T2, which is considered a strong association, according to Cohen, with a shared variance of about 40%. As shown in Table 1, the mean score of the AES-S and the AES-C is close to identical at both time points, with no significant differences at either T1 ($t = .23$; $p = .82$) or T2 ($t = .09$; $p = .96$).

There were no significant differences in mean scores between the three diagnostic groups at T1 (Table 3) for the AES-S [$F(2,82) = 2.774$; $p = .07$] or the AES-C [$F(2,82) = 2.67$; $p = .08$]. At T2, there was a significant difference between the diagnostic groups for both the AES-S [$F(2,82) = 4.35$; $p = .02$] and the AES-C [$F(2,82) = 13.69$; $p < .001$], with a difference in mean score for the AES-S between diagnostic group 1 (schizophrenia spectrum disorders) and Group 3 (affective psychotic disorders) and for the AES-C between diagnostic Group 1 and Group 2 (other psychotic disorders) and Group 3 (Table 3).

3.4 External convergent validity to the PANSS negative factor, subdomains, and items

The correlation between the AES scores and the PANSS negative factor and subdomains scores can be seen in Table 4. For the AES-S, the overall correlations are weak or modest, but with the same pattern of strength at T1 and T2. The strongest correlation for the AES-S at both time points is to the PANSS amotivation factor (T1: $r = .35$; $p = .01$; T2: $r = .38$; $p = .001$). Regarding association with specific PANSS negative items, (not in table) the strongest correlation for AES-S was found for items N2 (T1: $r = .34$; $p = .01$; T2: $r = .27$; $p < .05$) and N4 (T1: $r = .27$; $p < .05$; T2: $r = .37$; $p < .001$), with no significant correlation to other PANSS negative items. The association between PANSS factors and AES-C we found were considerably stronger, again with the strongest correlation to the PANSS amotivation factor (T1: $r = .60$; $p < .001$, T2: $r = .70$; $p < .001$) and also reaching the level of statistical significance for the PANSS deficit expressive factor (Table 4). Also for AES-C we found the strongest correlation to items N2 (T1: $r = .54$; T2: $r = .54$) and N4 (T1: $r = .47$; T2: $r = .63$)

Using a partial correlation analysis to study the influence from depression (Table 4), we found that the strength of correlations was reduced for both the AES-S and the AES-C, with the most prominent reduction for the AES-S. Here the correlation between AES-S and the PANSS negative - and Amotivation factor at T1 no longer reached the level of statistical significance. However, the reductions in r (to $.17$ and $.23$, respectively) was not statistically significant. The effect was smaller for both scales at T2. Controlling for positive symptoms and for insight made for minimal changes for both scales at both T1 and T2 (Table 4).

3.5 Discriminative validity to other PANSS factors, clinical variables and functioning

No significant associations were found between the AES-S and the PANSS positive, disorganized or excitative factors at either T1 or T2 (Table 5). The AES-S showed significant associations with the PANSS depressive factor and the CDSS (Table 5) at both T1 and T2, in concordance with the AES-C. Differing from the AES-C the AES-S only had significant associations to the DUP and the GAF-F at T2, of about equal strength as AES-C. For the AES-C, there was a significant correlation with the PANSS disorganized factor and GAF-F at T1 and with all the PANSS factors at T2.

3.6 Screening ability of the AES-S for high versus low apathy level as indicated by the AES-C

Based on a cut-off score for being apathetic of ≥ 27 , the AES-S identified 51% of participants at baseline and 41% at follow-up as apathetic; the corresponding figures for the AES-C were 57% and 44%. Based on a cut-off score of ≥ 27 for the AES-C used as the gold standard, the AUC for the AES-S at T1 was .77 (.67– .88), considered fair, and at T2, the AUC was .82 (.73 – .92), considered good. This cut-off score gives a sensitivity of 68.1% and a specificity of 67.6% at T1 and a sensitivity of 75.7% and specificity 85.1% at T2.

4. Discussion

4.1 Main findings

The main finding of this study is that persons with FEP can give a valid and reliable self-report of apathy using the AES-S, closely corresponding to the clinicians' evaluation using the AES-C. We found a high concordance between the AES-S and the AES-C regarding mean values, change from baseline to follow-up, and proportion with high apathy scores. The AES-S did not show the same degree of external validity towards the clinician-rated PANSS negative symptoms as the AES-C, but the two scales share the same pattern of significance for correlations with the PANSS negative factors and items, which also are stable over time. This gives support for the previously argued notion that the phenomena captured by the PANSS do not fully represent the current definition of apathy (Marin, 1991; Kaiser et al., 2017). The strength of the correlation between apathy and depression is equal for the AES-S and the AES-C. Controlling for degree of depression did not influence this association to a significant degree. However, the T1 association between AES-S and PANSS negative- and amotivation factors did no longer reach the level of statistical significance.

4.2 Concordance between AES-S and AES-C

This study found that the 12-item shortened AES-S had sound psychometric properties over a 12-month period with a high Cronbach's alfa at the same level as the AES-C. The same high Cronbach's alfa was also found in all other studies reporting on the AES-S, including the original by Marin (Marin et al., 1991) in addition to in chronic patients with psychosis (Evensen et al., 2012) and in studies of other neuropsychiatric disorders (Raimo et al., 2014; Sagen, U. et al., 2010a; Santangelo et al., 2014). The correlation between the AES-S and the AES-C is strong with a shared variance of about 40%, in line with Marin and Guercio et al.'s results (Marin et al., 1991; Guercio et al., 2015). A shared variance of 40% is also at the

highest level of reports for associations between self-ratings and clinician ratings in mental health assessments, as reported by the National Patient-Reported Outcomes Measurement Information system (PROMIS) for Mental Health Research (Riley et al., 2011). Moreover, our result is of the same magnitude as that of the three different studies comparing self- and clinician-rated versions of the MAP subfactor of the CAINS (Park et al., 2012; Llerena et al., 2013; Engel & Lincoln, 2016). Furthermore, contrary to what is often expected, participants with schizophrenia had a valid sense of being apathetic, in that they scored themselves with a higher mean score than did participants in the other two diagnostic groups, in line with the clinicians' assessment. The results from the CAINS-MAP studies as cited above and the present findings show that people with psychosis can validly self-report apathy and amotivation.

The AES has been subject to factor analysis within a wide range of disorders. Except for one study, these studies have revealed three factors: one major apathy factor and two minor factors (Raimo et al., 2014; Sagen, U. et al., 2010a; Santangelo et al., 2014). Sagen et al. compared the factor structure of the AES across different disorders, including patients from the current study, and found 10 shared items for the AES-S and the AES-C in the main apathy factor (Sagen, U. et al., 2010a). In the current study, we only found that one item (item 10) of the shortened 12-item AES-S had low item-total correlation. This item is not one of the ten shared items from Sagen's study. Deleting this item did not change psychometric properties. In Sagen's study, the number of participants was in the lower end of what is suitable for a factor analysis, and should, therefore, be repeated in a larger group to improve insight into the number of items that best represents the AES-S in FEP patients.

4.3 The AES-S and external validity based on the PANSS negative symptoms

Compared to the AES-S, the AES-C had a stronger correlation with the PANSS negative symptoms. Also, as hypothesized, the AES-S had the strongest correlation with the PANSS amotivation factor and the items N2 and N4 representing apathy. Shared variance with the PANSS amotivation factor was, however, lower than expected: only 12–14% compared to 36–49% for the AES-C. The same weak external validity between the AES-S and the PANSS negative symptoms was also found in studies of more chronic patients (Kiang et al., 2001; Sagen, U. et al., 2010a; Evensen et al., 2012). External validity was not tested in the self-rating studies of CAINS, but Dollfus et al., found a shared variance of 40% between the SNS and the Scale for Assessment of Negative Symptoms (SANS) (Dollfus et al., 2016). The better result may be due to the unique patient involvement in developing the SNS or that

the SANS represents negative symptoms more in line with patient perceptions than the PANSS.

The lower correlation between the PANSS negative symptoms and the AES-S, as compared to the AES-C, may have different explanations. First, there may be a bias based in the same clinician rating both the PANSS and the AES-C. Moreover, the PANSS is currently not regarded as the best assessment of negative symptoms (Kaiser et al., 2017; Marder & Galderisi, 2017; Lincoln et al., 2017), and it has fewer items covering apathy than newer negative symptom scales, such as the Brief Negative Symptoms Scale (BNSS) (Kirkpatrick et al., 2011) and the CAINS (Kring et al., 2013). Finally, the awareness of apathy may vary more amongst people in general, including patients, than amongst research clinicians who are trained to provide high inter-rater agreement.

4.4 The AES-S and the influence from depression, positive symptoms, and a lack of insight

As expected, the current study found significant associations between the AES-S and depression, which is also reported in three of the four newly published studies on self-reporting negative symptoms (Park et al., 2012; Engel & Lincoln, 2016; Dollfus et al., 2016; Llerena et al., 2013). It should be noted that the strength of these correlations are of equal magnitude for the AES-S and the AES-C, and stronger at T2 than at T1. In the partial correlation analysis controlling for depression, only the strength of associations between the AES-S and PANSS negative and amotivation factor were reduced and this reduction was not statistically significant. Controlling for depression had also no significant influence on strength of correlations between AES-C and PANSS negative symptoms. Taken together these results give support to the notion that apathy and depression are two separate phenomena with some common features, also when using self-reports (Marin et al., 1993; Simon et al., 2010; Morch-Johnsen et al., 2015; Hollocks et al., 2015). As hypothesized, we also found that self-reports of apathy were minimally influenced by positive symptoms and also that a lack of insight did not influence results. This was also found for the AES-C.

4.5 The AES-S and associations to other clinical variables and psychosocial functions

Regarding other clinical variables selected for the study, we only found significant correlations between the AES-S and the DUP at T2. High levels of self-reported negative symptoms and especially apathy in at-risk (Demjaha et al., 2012; Valmaggia et al., 2013) and

healthy young populations (Dominguez et al., 2009) have been found to predict a transition to psychosis. We have in a previous report from this study shown that enduring high AES-C scores (at T1 and T2) was independently associated with a long DUP and poor functioning (Faerden et al., 2010). These preliminary results regarding the AES-S and its association to the DUP are in need of further exploration.

We found a weaker association between the GAF-F and the AES-S than for the GAF-F and the AES-C, with no shared variance at T1 and increasing to 24% at T2. One explanation may be the degree of insight and expectations into one's own functioning, where poor functioning may be more acceptable to FEP patients than to the clinician. However, the clinicians may also be biased as the same person did all assessments. The use of a more specific functional assessment, including self-reports, may help clinicians understand how self-reported apathy may be associated with different aspects of functioning.

4.6 Screening for high levels of apathy using the AES-S

The proportion with high levels of apathy was the same, regardless of using the AES-S or the AES-C. The AUC for the AES-S versus the AES-C was fair to good with a cut-off score of ≥ 27 . Yet, this cut off did not yield acceptable sensitivity or specificity at T1 for the AES-S to screen for high levels, but at T2, the sensitivity and specificity were more satisfactory. It would be of interest to explore if a shorter version of the AES-S or another cut-off value for high apathy could improve sensitivity at T1. The number of participants in this study did, however, not allow for such explorations.

5. Limitations

The main limitations of this study are that the clinician was not blind to other assessments when scoring the AES-C. The number of participants is at the lower end for sound interpretations. We have used the PANSS negative symptoms, which was developed more than 40 years ago, for external validation. The representation of the different negative symptoms, such as apathy, in the PANSS are limited and not in line with the current concept and definitions.

6. Conclusions

This is the first study to investigate an apathy self-report scale in participants with FEP. Moreover, it is the first follow-up study to investigate self-reports of negative symptoms. We found similar properties for self-report and clinician assessment of apathy, but also some differences that are in need of further investigation. The concordance between the AES-S and the AES-C is strong and demonstrates that people with FEP can validly self-report apathy. It is important to understand the limits of the concordance between self-rating and clinician rating, but also to value those differences that can complement our understanding of psychosis. More work should be carried out to refine the AES-S and understand its strengths and shortcomings in people with psychosis. This should include patients with a longer duration of illness for a fuller understanding of how self-reports can be used and how apathy is perceived during different stages of illness. Investigating the associations between the AES-S and other self-reporting scales, such as the SNS and the MAP-SR, will be valuable for a deeper understanding of the patient's perception of apathy and reduced motivation. It is also of interest to study how the AES-S is associated to the new negative symptoms scales CAINS and BNSS to understand more of the modest to non-significant associations between the AES-S and the PANSS negative symptoms.

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Conflict of interest

The authors have declared that there are no conflicts of interest in relation to the subject of this study.

Authors' contributions

AF: study design, collecting data, analysis, drafting and revising the manuscript. SHL: discussion and revision of manuscript; CS: discussion and revision of manuscript, PAR:

discussion and revision of manuscript; OP: discussion and revision of manuscript; ID: discussion and revision of manuscript; OAA: conception of the study and revision of manuscript; IA: conception of the study and revising the manuscript; SRM: conception of study, discussion and revision of manuscript IM: conception of the study, study design, data analysis and revising the manuscript. All authors contributed to and have approved of the final version of the manuscript.

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Table 1
Demographics and clinical characteristics

	T1 (<i>n</i> = 84) <i>n</i> (%), M (SD)		T2 (<i>n</i> = 84) <i>n</i> (%), M (SD)		<i>t</i>	<i>p</i>
Sex (Male)	54	(60%)				
Age	27	(7.9)				
Years education	12.7	(2.7)				
DUP (median) weeks	39	1-1040				
Group 1: Schizophrenia spectrum	49	(55.7%)	57	(64.8%)		
Group 2: Affective w/psychosis	17	(19.3%)	20	(22.7%)		
Group 3: Other psychotic disorders	22	(25.0%)	11	(12.5%)		
GAF-F	45.05	(13.6%)	53.67	16.47	-5.65	<.001
PANSS total	61.51	(14.83)	53.73	(14.89)	5.17	<.001
PANSS positive	14.86	(5.39)	12.42	(5.25)	4.02	<.001
PANSS negative	15.02	(6.04)	13.73	(5.25)	1.98	.051
PANSS general	31.63	(7.45)	27.58	(7.42)	5.02	<.001
CDSS	6.51	(4.56)	4.78	(4.07)	3.73	<.000
AES-S (12-item)	27.54	(7.00)	25.27	(7.12)	3.05	.003
AES-C (12-item)	27.46	(7.51)	25.06	(7.13)	2.92	.004
AUDIT	6.82	(7.07)	6.48	(6.80)	1.24	.218
DUDIT	5.83	(9.66)	4.59	(8.64)	1.20	.234

Note: T1, Assessment at inclusion; T2, Assessment 12 months after inclusion; DUP, Duration of Untreated Psychosis; GAF-F, Global Assessment of Functioning Scale Functioning; PANSS, Positive and Negative Syndrome Scale; CDSS, Calgary Depression Scale for Schizophrenics; AES-S, Apathy Evaluation Scale Self-report; AES-C, Apathy Evaluation Scale Clinician rated, AUDIT, Alcohol Use Disorder Identification Test; DUDIT, Drug Use Disorder Identification Test

Table 2Item total correlation (*r*) AES-S

	T1	T2
1: S/he is interested in things	.666	.795
2: S/he gets things done	.598	.647
4: S/he is interested in new experiences	.608	.721
5: S/he is interested in learning new things	.717	.695
6: S/he puts little effort into anything	.719	.765
7: S/he approaches life with intensity	.666	.596
9: S/he spends time doing things that interest her/him	.800	.716
10: Someone has to tell her/him what to do each day	.273	.353
14: When something good happens s/he gets excited	.673	.731
16: Getting things done during the day is important	.618	.655
17: S/he has initiative	.760	.785
18: S/he has motivation	.655	.757

Note: AES-S, Apathy Evaluation Scale Self-report

Table 3

AES-S and AES-C: Mean score between diagnostic groups

	Group 1	Group 2	Group 3	Post hoc
<u>T1</u>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	
AES-S	26.98 (7.12)	30.94 (5.87)	26.00 (6.87)	n.s
AEC-C	28.33 (7.15)	29.06 (6,23)	24.29 (8.56)	n.s
<u>T2</u>				
AES-S	26.58 (7.06)	24.60 (7.24)	19.70 (4.21)	1>3; 1=2
AEC-C	27.57 (7.38)	21.90 (4.52)	17.80 (4.02)	1>2,3

Note: Group 1 = Schizophrenia spectrum disorders (schizophrenia, schizophreniform disorder, schizoaffective disorder); Group 2 = Affective psychotic disorders (affective disorder with mood incongruent psychotic symptoms and bipolar I disorder); Group 3 = Other psychotic disorders (psychosis not otherwise specified (NOS), delusional disorder, brief

psychotic disorder); M = mean score; SD = standard deviation; AES-S, Apathy Evaluation Scale Self-report 12-item shortened version; AES-C, Apathy Evaluation Scale clinician rated 12-item shortened version.

Table 4

AES-S and AES-C: Partial correlations to PANSS negative factor and subdomains when controlling for Depression (CDSS), Positive symptoms (PANSS positive factor) and Insight (PANSS item G12) ($n=84$)

	T1								T2							
	AES-S				AES-C				AES-S				AES-C			
PANSS	O _{ri}	D _{ep}	P _{os}	I _{ns}	O _{ri}	D _{ep}	P _{os}	I _{ns}	O _{ri}	D _e	P _{os}	I _n	O _{ri}	D _{ep}	P _{os}	I _{ns}
Negative factor	.28*	.17	.32*	.29*	.54*	.52*	.48*	.55*	.30**	.25*	.25*	.27*	.61*	.61*	.50*	.52*
Amotivation factor	.35**	.23	.42*	.37*	.60*	.52*	.47*	.57*	.38*	.26	.33	.35	.70*	.66*	.63*	.65*
Deficit expr factor	.18	.12	.21	.19	.46*	.46*	.42*	.46*	.20	.21	.17	.19	.39*	.42*	.35*	.39*

Note: PANSS, Positive and Negative Syndrome Scale; O_{ri}, Original correlation, not controlled for symptoms or insight; D_{ep}, Controlling for depression with CDSS; P_{os}, Controlling for positive symptoms with PANSS positive factor; I_{ns}, Controlling for insight with PANSS G12 Insight item; AES-S, Apathy Evaluation Scale Self-rated 12-item shortened version; AES-C, Apathy Evaluation Scale clinician rated 12-item shortened version

* = $p \leq .05$; ** = $p \leq .01$; *** = $p \leq .001$

Table 5

Correlations (*r*) between AES-S and AES-C and clinical variables assessed at intake and at 12 months

	T1		T2	
	AES-S	AES-C	AES-S	AES-C
Gender (male)	.03	.15	.22	.30**
Age	.02	-.03	.04	.07
PAS total				
Childhood	.20	.15	.16	.17
Early Youth	.14	.13	.17	.12
Late youth	.17	.16	.14	.13
Years of education	-.02	-.08	-.17	-.17
DUP (ln)	.13	.11	.36**	.41***
GAF-F	-.13	-.46***	-.49***	-.64***
PANSS factors				
Positive	-.07	.14	.21	.43***
Disorganized	-.09	.27*	.17	.45***
Depressive	.29*	.26*	.48***	.48***
Excitative	-.16	-.10	.08	.06
CDSS	.42***	.42***	.54***	.46***

Note: AES-S, Apathy Evaluation Scale Self-report 12-item shortened version; AES-C, Apathy Evaluation Scale clinician rated 12-item shortened version; PANSS, Positive and Negative Syndrome Scale; CDSS, Calgary Depression Scale for Schizophrenics; PAS, Premorbid Assessment of functioning Scale; DUP(ln), Duration of Untreated Psychosis logarithmic transformed; GAF-F, Global Assessment of Functional Scale Functioning score.

* = $p \leq .05$; ** = $p \leq .01$; *** = $p \leq .001$