Letters

COMMENT & RESPONSE

In Reply We thank van Os for his interest in our article.¹ We agree that the evidence of association between schizophrenia genetic risk and negative symptoms, but not with psychotic experiences, could be due to greater measurement error when assessing psychotic experiences, as stated in the Discussion section of our article.¹

However, we believe it is unlikely that the Community Assessment of Psychic Experiences (CAPE) self-report questionnaire negative symptom items are a more valid marker of psychotic experiences than the semi-structured Psychosis-Like Symptom Interview (PLIKSI). During the PLIKSI, individuals are assessed by psychology graduates trained in assessment using the Schedules for Clinical Assessment in Neuropsychiatry psychosis section and the interview itself shows very good interrater and test-retest reliability.^{2,3} Semi-structured interviews, as used in clinical practice, allow a more valid assessment of psychotic experiences than self-report questionnaires. Furthermore, given the similarity between the CAPE positive dimension and the PLIKS questionnaire (PLIKSq) (both contain items relating to bizarre experiences, perceptual abnormalities, paranoid ideations, and grandiosity and wording is similar, for example, “Do you ever see objects, people or animals that other people cannot see?” [CAPE] and “Have you ever seen something or someone that other people could not see?” [PLIKSq]), it is unlikely that schizophrenia genetic risk would be associated with CAPE psychotic experiences (via the negative symptom dimension as a proxy) and not the PLIKSq (see eFigure 2 in the Supplement of our article).¹

However, we agree that negative symptoms are likely to be correlated with psychotic experiences and, in our bivariate analysis, there was only weak evidence that effect estimates for psychotic experiences and negative symptoms were different from each other. This correlation might be higher in clinical samples, such as the Genetic Risk and Outcome of Psychosis Study, than in population-based (not clinically ascertained) samples, such as the Avon Longitudinal Study of Parents and Children (ALSPAC) (correlation between negative symptoms and psychotic experiences in our study was 0.30). Future investigations of associations between schizophrenia genetic risk and psychopathology could involve relevant frameworks that account for this, for example, by modeling symptoms as correlated latent constructs.⁴

Finally, while our earlier work reported little evidence of association between the PLIKSI measure of psychotic experiences and family history of schizophrenia in ALSPAC, confidence intervals were wide as there were relatively few individuals with a family history of schizophrenia in that study.⁵

It would be very surprising if psychotic experiences are not related to genetic risk for schizophrenia. However, our over-

all patterns of results from ALSPAC do suggest that psychotic experiences, as assessed by questionnaire or interviews, are not as strongly associated with genetic risk for schizophrenia during adolescence as other aspects of psychopathology. Whether this is due to measurement error issues or a true reflection of how genetic risk for schizophrenia is manifest during development remains to be seen.

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