Prevalence and impact of childhood abuse in people with a psychotic illness. Data from the second Australian national survey of psychosis

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ABSTRACT

Child abuse has been associated with risk of mental illness, including schizophrenia and other psychotic disorders and, among those with mental illness, with a more severe clinical profile. Using an extensively characterised and epidemiologically representative sample of 1825 Australians with a psychotic illness aged 18–64 years and in contact with mental health services, we estimated the proportion of individuals with psychotic disorders who self-reported child abuse and examined its relationship with clinical and other characteristics. The prevalence of child abuse in this nationally representative sample of people with psychotic illness was 30.6%. Women were almost three times more likely to report child abuse compared to males (OR, 2.8, 95% CI 2.3–3.4). When adjusted for age at interview and socio-economic status, there was no significant relationship between self-reported child abuse and type of psychosis or course of illness. Participants with child abuse were significantly more likely to have subjective thought disorder, lifetime suicide attempt and premorbid personality disorder (females only) and anxiety (males only). Our findings demonstrate that child abuse is relatively common across the range of psychotic disorders, with an elevated risk for women in particular, compounding the already high burden associated with psychotic illness. Clinicians need to inquire routinely about child abuse in order to develop appropriate treatment plans tailored to individual needs.

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1. Introduction

Bromfield and Holzer (2008) define child abuse as maltreatment that involves non-accidental behavior towards another person, which is outside the norms of conduct and entails substantial risk of causing physical or emotional harm. Behaviors may be intentional or unintentional and include acts of omission and commission (Bromfield and Holzer, 2008). The experience of child abuse has been associated with an elevated prevalence of a number of psychiatric disorders including depression, anxiety, post-traumatic stress disorder, eating disorders, substance abuse, sexual dysfunction, personality disorders and dissociative disorders (Beitchman et al., 1992; Boney-McCoy and Finkelhor, 1996; Kendler et al., 2000; Paolucci et al., 2001; Cutajar et al., 2010; Gonzalez et al., 2012). It has also been associated with the risk of adult psychosis (Varese et al., 2012) including schizophrenia (Matheson et al., 2013). However, evidence of the link with the spectrum of psychotic disorders has been inconsistent (Morgan and Fisher, 2007) and specificity for schizophrenia relative to

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other psychiatric disorders has not been clearly demonstrated (Chen et al., 2010). A review of 26 studies of clinical samples found that the prevalence of reported child abuse among individuals with a diagnosis of psychosis ranged between 28% and 73% (Bendall et al., 2008). Variability in prevalence may be due to methodological differences including the definition of child abuse employed, problems of recall bias in retrospectively collected data and reliance on small studies using diagnostically heterogeneous and chronic samples.

Studies that have examined child abuse in people with a psychiatric disorder report significant and sustained negative effects in adulthood. Compared to psychiatric patients who did not report abuse, those abused as children have been found to have worse overall social functioning (Gil et al., 2009; Hodgins et al., 2009); poorer academic performance (Paolucci et al., 2001; Arias, 2004); longer and more frequent hospitalisations (Read et al., 2005); lower remission rates (Neria et al., 2005); and poorer adherence to treatment (Conus et al., 2010). Studies have consistently reported a strong relationship between child abuse and suicidal ideation (Santa Mina and Gallop, 1998; Evans et al., 2004; Cash and Bridge, 2009), with psychiatric patients who have been abused more likely to self-harm and attempt suicide (Read et al., 2009) compared with those with no child abuse history. Evidence from prospective and retrospective studies suggest that severity of abuse and multiple episodes of abuse further strengthen the association (Brezo et al., 2008; Fergusson et al., 2008). A history of child abuse has also been associated with greater likelihood of positive symptoms (Ross et al., 1994), particularly hallucinations (Janssen et al., 2004) in people with psychosis. The association appears strongest between physical or sexual abuse and auditory hallucinations (Sansonnet-Hayden et al., 1987; Heins et al., 1990; Read and Argyle, 1999; Read et al., 2003). This association has also been reported in individuals with bipolar affective disorder (Hammersley et al., 2003). However, to date, many studies have relied on small samples, a single form of abuse, generally sexual abuse, within a single diagnostic group, with access to a limited range of clinical and other outcomes.

In this study, our aim was to determine the prevalence of retrospectively reported child abuse of any form in a large, representative sample of 1825 adults with psychotic disorders, and to examine the relationship of abuse in this sample to a wide range of demographic, clinical and other characteristics, including functioning and physical health, as well as to assess diagnostic specificity. We were specifically interested in answering the following questions:

1. What is the prevalence of childhood abuse in this nationally representative sample of people with psychotic illness?
2. Do people with a psychotic illness who report childhood abuse have different demographic and functioning, clinical and physical health profiles compared to people with a psychotic illness who do not report childhood abuse?
3. Is there evidence of specificity of childhood abuse to affective or non-affective psychosis?

2. Methods

2.1. Design and study sample

This paper is based on data collected as part of the 2010 Australian National Survey of Psychosis: the Survey of High Impact Psychosis (Morgan et al., 2012, 2014). The survey was conducted within seven catchment sites across five Australian states, covering a population of 1.5 million adults aged 18–64 years, approximately 10% of the Australian population in this age range. A two-phase design was used. In Phase 1, screening for psychosis took place in public mental health services and in non-government organisations supporting people with a mental illness. The psychosis screener used had been developed for the first Australian national psychosis survey (Jablensky et al., 1999; Jablensky et al., 2000). Pilot testing prior to the second survey led to

minor modifications and improved psychometric properties with excellent sensitivity (0.96, 95% confidence interval 0.87–1.00) and good specificity (0.88, 95% confidence interval 0.47 − 1.00). Screening items covered hallucinations and delusions (six items) and being on antipsychotic medication (key worker version) or being told by a doctor that a person had a psychotic disorder (version administered by a key worker to new clients). For the survey, the screen-positive cut-off was a positive rating on two or more of these items. In Phase 2, people who were screen positive for psychosis in Phase 1 were randomly selected, stratified by age group (18–34 years and 35–64 years), for interview and assessment. The census month was March 2010. Of 7955 people who were screen positive for psychosis and eligible, 1825 were interviewed. The survey methodology has been published in full (Morgan et al., 2012).

2.2. Assessments

The interview schedule consisted of 32 modules including the following domains: psychopathology; substance use; physical health; functioning, disability and quality of life; education, employment and accommodation; and childhood adversity. Interviewers were predominantly mental health professionals seconded from public mental health services. To reduce inter-site differences, interviewers received specialised training in administering and scoring the survey instrument. Procedures were implemented to ensure quality and reliability of the assessments. National training workshops were conducted for all interviewers, in addition to onsite training, with weekly inter-site teleconferences throughout the survey. Inter-rater reliability was assessed in the course of the field interviews and the level of agreement achieved among interviewers was good (averaged pairwise agreement of 0.94 for ICD-10 diagnoses and intra-class correlation of 0.98 for the National Adult Reading Test).

2.2.1. Child abuse

Child abuse was classified by the interviewer in the course of the face-to-face interview. The interview included questions on childhood trauma in the childhood adversity module of the survey instrument. In Australia, child abuse and protection is a state and territory government responsibility. However, all states follow a national framework of guidelines for defining the four types of child abuse: (a) sexual abuse, (b) physical abuse, (c) emotional abuse, and (d) neglect (Australian Institute of Health and Welfare, 2012). The classification of a trauma as an instance of child abuse was done under the guidance of staff from the Western Australian Department of Child Protection to ensure conformity to national guidelines. Two raters independently coded each of the responses. Agreement between the two coders was 96%; a consensus decision was reached on remaining items. This paper includes only those cases where the abuse met the standard Australian definitions (Bromfield and Holzer, 2008), took place when the participant was aged 18 years or younger, and had occurred before the onset of psychotic illness. An additional 463 participants described other forms of childhood trauma or abuse that did not meet the Australian definitions of child abuse and were consequently considered as non-cases.

2.2.2. Psychopathology

ICD-10 diagnoses were determined using a semi-structured clinical research interview, the Diagnostic Interview for Psychosis (DIP) (Castle et al., 2006). The DIP contains selected interview questions and probes from the WHO Schedules for Clinical Assessment in Neuropsychiatry (Wing et al., 1990) mapped onto the 90 diagnostic items of the operational criteria checklist for psychotic and affective illness (McGuffin et al., 1991). A computer algorithm provides diagnostic classification in accordance with ICD-10, DSM-IV and other criteria on the basis of the DIP scores, thus reducing subjective bias in the interpretation of symptoms and signs.