European Psychiatry 28 (2013) 154–160

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Original article

Childhood trauma and distress experiences associate with psychotic symptoms in patients attending primary and psychiatric outpatient care. Results of the RADEP study

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ARTICLE INFO

Article history:
Received 27 April 2011
Received in revised form 20 October 2011
Accepted 11 November 2011
Available online 18 April 2012

Keywords:
Psychotic symptoms
Childhood distress
Primary care
Psychiatric care

ABSTRACT

Goal: We studied the prevalence of and association between psychotic symptoms and childhood trauma experiences in primary care patients compared with psychiatric care patients.
Patients and methods: We note 911 primary care and psychiatric care patients over 16 years of age filled in a questionnaire including a list of lifetime psychotic symptoms of the Composite International Diagnostic Interview (CIDI) and the childhood Trauma and Distress Scale (TADS). Prevalence of and correlations between psychotic symptoms and childhood trauma and stressful experiences were calculated. Association between the sum of CIDI symptoms and the TADS sum score was analysed by Anova.
Results: In primary care, more than half of the patients had had at least one psychotic symptom during their lifetime, and nearly 70% of patients had experienced a childhood trauma at some time or more often. In psychiatric care patients, CIDI symptoms were more prevalent and TADS scores were higher than in primary care patients. In the whole sample, CIDI symptoms correlated with TADS scores. The association remained even when the effects of age, service, and patient's functioning were taken into account. There was a dose-response between TADS scores and CIDI symptoms.
Conclusion: Childhood trauma experiences associate with psychotic symptoms. In clinical work, it is important to acknowledge that psychotic symptoms and childhood trauma experiences are common not only in psychiatric care but also in primary care patients, and thus require adequate attention.

1. Introduction

Poor psychosocial development in childhood and adolescence is associated with schizophrenia and other psychotic disorders, and predicts poor outcomes in patients with these disorders [3,4,9,15,26,28,32]. In population studies, childhood trauma and stressful experiences (CTSEs) associate with psychotic symptoms (PSs) [7,17,20,37,42], which are common in the general population [18,39]. Lataster et al. and Spauwen et al. showed a dose-response link between traumatic childhood experiences and PSs. Psychotic patients have a history of childhood trauma more often than healthy controls [14] or non-psychotic psychiatric patients [6]. An important question is the reliability of self-report of abuse, which may cause problems in interpreting the results of most studies. However, individuals who were ascertained from the registers as having been sexually abused were shown to have a higher rate of psychosis and schizophrenia compared with matched population controls [11]. One of the theories explaining the association between CTSEs and PSs is the neurodevelopment effects of trauma on children's brains, particularly damage to the stress regulation mechanisms in the hypothalamic-pituitary-adrenal axis [31]. It has been suggested that especially those psychotic patients who have suffered childhood trauma would benefit from psychosocial treatments [19,31]. Among patients at ultra-high-risk of psychosis, previous sexual trauma is associated with conversion to psychosis [8]. Weinreb et al. [41] showed that less than one third of primary care physicians usually or always screened their patients' traumatic experiences. In primary care, both CTSEs [13,29] and PSs [25] are prevalent, but to our knowledge, their association in primary care has not been studied. The purpose of our study was to study the prevalence and association of CTSEs and PSs in primary care (PrC) patients in comparison with psychiatric care (PsC) patients.

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doi:10.1016/j.eurpsy.2011.11.005

2. Patients and methods

2.1. Participants

This study comprises consecutive 16+-year-old patients visiting a physician in PrC services and attending PsC outpatient services during about two months in spring 2003 and spring 2004. In Finland, PrC takes care of patients with mild to moderate depression and anxiety disorders. In case of treatment-refractory cases of depression/anxiety disorders or if bipolar disorder or psychosis is suspected, patients are referred to PsC.

The flowchart of the study is shown in Fig. 1. In all, 3132 patients were invited to participate in the study. Of the eligible patients, 1542 (49.2%) refused and 1641 (1358 PrC and 283 PsC patients) participated. Men and young people refused more often than women and older patients. In 2005, another questionnaire including the Trauma and Distress Scale (TADS) [27] was mailed to the patients who had participated in 2003–2004. Of the participating patients, 1547 returned the completed questionnaire, but only in 911 cases (733 PrC [54.5% of PrC participants] and 178 [62.9%] PsC patients) were complete TADS data available. These 911 patients form the present study sample; their sociodemographic background is shown in Table 1. Compared with those patients who did not complete the TADS, the study subjects were older, less often single but more often married or divorced, more often retired, and less often in full-time work. There was no gender difference between study subjects and drop-outs.

The study protocol was approved by the ethical committee of the University of Turku and the Turku University Central Hospital. Details of the study sampling and methods used in the first phase of the study are described in an earlier report [34].

2.2. Instruments

This study is based on data from the questionnaire which included questions on the patient's sociodemographic background, present general health status and functioning (from 1 very good... to 5 very poor). The questionnaire included a symptom list of 22 questions (yes = 1, no = 0) from the core psychosis section of the Composite International Diagnostic Interview (CIDI) ([43], Table 2), and the TADS [27], which is a 43-item list of trauma and distress experiences (0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = nearly always) in childhood. The TADS includes five domains [27]: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect, which are formed by summing certain items as shown in Table 5. The sum of TADS was formed by summing the TADS domains. For a stricter definition of trauma experiences, the TADS domains were also calculated from dichotomised (0–1/2–4) items and their sum was used in Fig. 2.

2.3. Analyses

Proportions of patients with individual CIDI symptoms and individual dichotomised TADS items were calculated by services and the difference was tested by Fisher's Exact Test. Means for CIDI and TADS domains were calculated by services and the difference tested by Anova. Spearman correlation (r) between individual TADS items and TADS domains and CIDI sum score was calculated. Association between CIDI sum scores (dependent variable) and TADS domains (independent variable) was analysed in the general linear model of Anova, and the effect of background variables (confounding variables) was taken into account. In modelling, variables with non-significant association were excluded step-by-step until all variables in the model had a

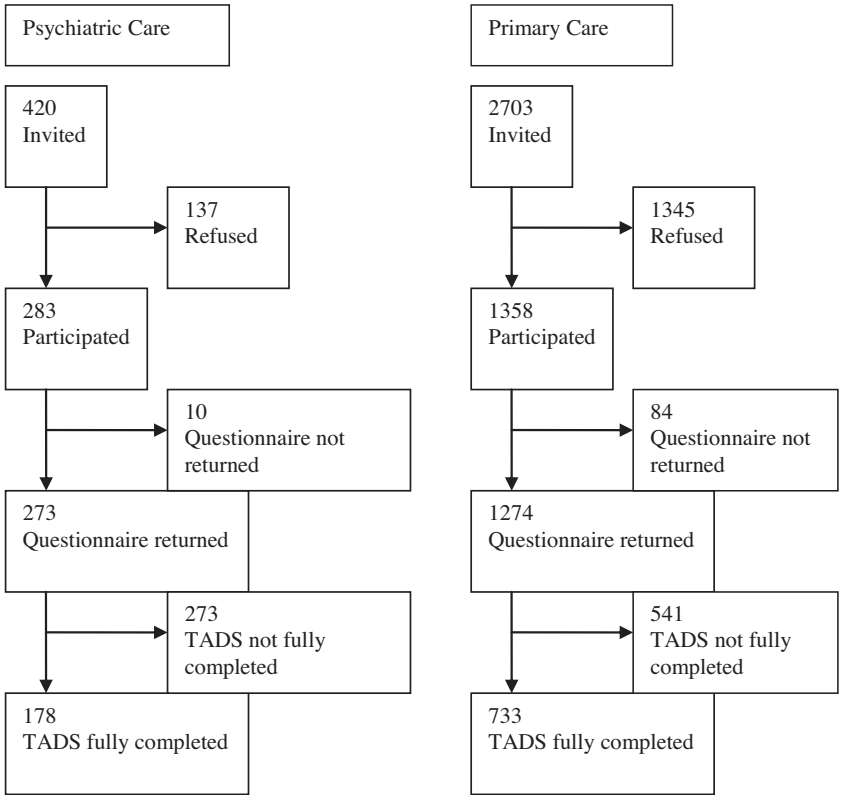

Fig. 1. Flow chart of the study.