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Childhood trauma and psychosis: Beyond the association



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ABSTRACT

Childhood traumas have been extensively associated with the development of psychotic disorders. However, our understanding of processes underlying this relationship remains poor. In order to address this issue, we examined which specific aspects of childhood trauma are significantly associated with a first episode of psychosis. 109 patients with first episode of psychosis and 145 controls representative from general population were recruited in three centers in France. Child experiences of care and abuses allowed obtaining information about types of childhood trauma, age at first exposure, identity of perpetrator, and social support. Odds ratio were calculated for each of these aspects, adjusted for age, sex, and education. Sexual and physical abuses (OR = 2.26 (1.19–4.32)), and separation from one or both parents (OR ranging from 1.94 to 3.17; all significant) are significantly associated with an increased risk to present a first episode of psychosis. Furthermore, separation from mother occurring before age of 4 (OR = 5.96 (1.24–28.77)), and sexual and physical abuses perpetrated by someone other than parents (OR = 4.61 (1.66–12.80)) were also associated with an increased risk of first episode of psychosis. Finally, social support was significantly associated with a decreased risk to develop psychotic disorders (OR ranging from 0.33 to 0.42; all significant). Together, these findings suggest that some but not all aspects of childhood trauma are related to a significant risk to develop a first episode of psychosis.

1. Introduction

Exposure to childhood traumas (CTs) has been recurrently identified as an environmental risk factor for developing psychotic symptoms and disorders in adulthood (for a meta-analysis, see Varese, Smeets et al., 2012). However, our comprehension of the processes that underlie this relationship is still incomplete. This may be due to only a relatively few characteristics of traumas having been investigated (Castellini, Maggi, & Ricca, 2014; Fisher et al., 2010).

Indeed, most previous studies have focused on childhood sexual abuse (CSA) and childhood physical abuse (CPA), investigating their cumulative effects in order to evaluate their detrimental impact on mental health (Fisher et al., 2009; Shevlin, Houston, Dorahy, & Adamson, 2007). Several other types of CTs have been relatively overlooked. For example, only a few studies have shown an elevated risk to develop psychosis after an exposure to other types of CTs, such as childhood psychological trauma (Ackner, Skeate, Patterson, & Neal, 2013), peer-victimization or bullying (Kelleher, Harley, Lynch, Arseneault, Fitzpatrick, & Cannon, 2008; Lataster

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et al., 2006; Trotta et al., 2013), and separation from parents (Morgan et al., 2007). Inter-parental violence can contribute to alterations in brain development, emotion processing and regulation, and attachment bonding (Carpenter & Stacks, 2009), which can all be evident in psychotic disorders (Harder, 2014; Read, Perry, Moskowitz, & Connolly, 2001). Some researchers found significant associations between inter-parental violence and psychotic symptoms in adolescents (Goodwin, Fergusson, & Horwood, 2003; Kelleher et al., 2008). However, to date, these types of CT have never been explored in connection with the risk for psychotic disorders.

CTs rarely occur in isolation. In the Adverse Childhood Experiences Study (n = 8 506), 65–93% of children exposed to one type of adverse event were exposed to one other type, with 40–74% exposed to at least two other CT types (Felitti et al., 1998). Also victims of CTs are at heightened risk of experiencing re-victimization (Castellini et al., 2014; Muenzenmaier et al., 2015). Cumulative adversities have been found to increase the risk for psychotic disorders, while exposure to only one type of CT has not (Shevlin et al., 2007). Notwithstanding the importance of these results, evaluation of CTs has often been limited (e.g. endorsement of one question to consider a trauma present), and requires replication.

Outwith CT type, other aspects of CTs can moderate the relationship with psychotic disorders, such as age at first exposure, which is not clarified in many studies (Fisher et al., 2010; Spauwen, Krabbendam, Lieb, Wittchen, & van Os, 2006). Clearly these additional moderating factors require fuller investigation.

Fisher and colleagues also noted that the risk to develop psychosis was increased when the perpetrator was the mother, compared to the father or both parents (Fisher et al., 2010), indicating the importance of perpetrator identity. However, we are not aware of published results about the relationship between CTs perpetrated by someone other than parents (e.g. uncle, cousin, family friend, or stranger) and psychotic disorders.

If some characteristics of CTs can increase the risk of developing mental disorders, others factors can decrease this risk. For example, higher levels of social support, whether intra- or extra-familial, moderate long-term mental health consequences. Lack of social support is more prevalent in people with psychotic disorders compared to the general population (Fisher et al., 2010). Furthermore, women who experienced severe CTs and had low social support were most at-risk of developing a psychotic disorder, indicating the moderating effect of social support (Gayer-Anderson et al., 2015).

To date, our comprehension of the relationship between exposure to CTs and the onset of psychotic disorders is still scarce. This is due to a focus on specific types of CTs (e.g. CPA and CSA), and a neglect of others (e.g. parental discord, or raw evaluation of CTs). Furthermore, previous studies lack details about important characteristics of CTs, such as: age at first exposure (e.g. comparisons before versus after 12 years of age); relationship with the perpetrator (e.g. no data about perpetrators other than parents); and social support (e.g. only investigated in regards to CPA and CSA).

In order to shed some light on this relationship, we systematically examined exposure to several adverse experiences, among patients with a first episode of psychosis (FEP) and controls. It was hypothesized that the different types of CTs (i.e. types and cumulative exposure) would specifically increase the risk to develop psychotic symptoms. Furthermore, we expected that some aspects of CTs, namely age at first exposure, victim-perpetrator relationship and social support, would moderate this risk.

2. Methods

2.1. Population

Cases (n = 109) and controls (n = 145) were recruited as part of a large European study: the European network of national networks studying gene-environment interactions (www.eu-gei.eu). This international scientific collaboration network has been described in detail elsewhere (European Network of National Networks studying Gene-Environment Interactions in Schizophrenia (EU-GEI), 2014). The present study focused on a French database. Data were collected between June 1st 2010 and May 31st 2014 in three centers, one located in a rural area (Clermont-Ferrand surroundings), and two in highly urbanized areas (Paris and Créteil). Cases were aged from 18 to 64, lived in a catchment area at the time of inclusion, showed a first-episode of psychosis or affective disorder with psychotic features (i.e. 295.xx, 297.x, 298.x, 296.x4 DSM-IV-TR codes), and were antipsychotic-naïve before the inclusion period (APA, 2000).

During the same period of recruitment, we advertised in highly frequented public places, such as bakeries and pharmacies as well as in city journals in order to recruit controls. The advertisement stated that the National Institute of Health and Medical Research (INSERM) was looking for volunteers aged between 18 and 64 years who lived in the recruitment area to participate in a medical research project consisting of interviews and questionnaires, as well as having a blood sample taken. The duration of the whole protocol administration was about four hours. A financial compensation was provided for participation. We also left our phone coordinates so volunteers could call the investigators and let them know they wanted to participate to the study. The same inclusion criteria as cases were applied to controls, except that they could not have a history of a psychotic disorder. Each respondent was screened twice. The first screening occurred when the potential participant called the investigator regarding inclusion in the study. Callers were asked whether they had any antecedent psychiatric disorder. If they reported any antecedent psychotic disorder, callers were not included in the study. Subsequently, Diagnostic Interview for Genetic Studies screening items for psychotic disorders (e.g. delusional ideations, hallucinations) were asked during the clinical interview with the investigator. Control participants were excluded if they endorsed any of these screening items. Controls were age, sex, and dwelling-matched with the general population, with the sole exception of migration history (2 time as many migrants as the general population). 67% of controls were recruited in one of the urban centers and 33% in the rural center.

This project was approved by an Ethical Board (Comité de Protection des Personnes – Ile-de-France IX) and the French National

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