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Childhood trauma and the risk of violence in adulthood in a population with a psychotic illness

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ABSTRACT

There are strong links between childhood trauma and the risk of violence (Ford et al., 2007). Despite evidence that people with psychotic disorders are at a higher risk of violence than the general population (Witt et al., 2013) there have been few studies that have examined the trauma-violence link in this population (Spidel et al., 2010). This study explored the association between a history of childhood trauma (abuse, neglect and conflict-related trauma) and the risk of violence in adults with psychotic disorders. The strongest associations with the risk of violence were found for sexual abuse ($r = .32$, $p < .05$) and the impact of community conflict ($r = .32$, $p < .05$). An accumulative effect of trauma was found using a hierarchical regression (adjusted $R^2 = .14$, $F(2,37) = 4.23$, $p < .05$). There are implications for applying models of violence to psychosis, risk assessment and treatment of people with psychotic disorders as well as informing trauma models and protective factors for children in conflict-affected regions.

1. Introduction

It is widely accepted that childhood trauma increases the likelihood of violent behaviour (Ford et al., 2007). Research within the juvenile justice system has found higher rates of childhood abuse and neglect than in the rest of the population (Spitzer et al., 2006). In particular, childhood physical and emotional abuse and neglect has been found to be associated with the risk of violent behaviour, aggression (Day et al., 2013) and hostility (Dyer et al., 2013). A history of childhood sexual abuse has been specifically linked to victimisation through domestic violence (Seedat et al., 2005), aggressiveness (Shapiro et al., 2012) self-harm and the perpetration of sexual offences (Paolucci et al., 2001) in adult life. Childhood trauma has also been linked to risk factors which are themselves associated with violence such as substance misuse (Triffleman et al., 1995), unemployment (Sansone et al., 2012) and relationship instability (Colman and Widom, 2004).

Additionally, complex trauma, referring to repeated and prolonged exposure to interpersonal victimisation (Dyer et al., 2013), through the experience of community conflict has been linked to elevated psychiatric morbidity (Catani et al., 2008), aggression (Dyer et al., 2009), hostility (Jakupcak and Tull, 2005), increased risk behaviours (Harel-Fisch et al., 2010) and perpetration of interpersonal violence (Byrne and Riggs, 1996). This association has been found in a number of current and post-conflict countries and regions such as Sierra Leone (MacMullin and Loughry, 2004), Bosnia (Allwood et al., 2002) Israel and the occupied Palestinian territories (Harel-Fisch et al., 2010) and Vietnam (Byrne and Riggs, 1996).

Research into both childhood abuse and conflict-related trauma has suggested that there is a cumulative effect where exposure to multiple types of childhood trauma and higher intensity of traumatic events increases the risk of later difficulties (Perkins and Graham-Bergmann, 2012) including physical aggression (Dyer et al., 2009) and psychotic illness (Read and Bentall, 2013). However, exposure to interpersonal violence in childhood has been found to be a stronger predictor of later difficulties than exposure to political violence (Dubow et al., 2012; Dyer et al., 2013). This may be explained by findings that family stability or at least the absence of family violence can provide a buffer to the effects of conflict-related traumatic events (Harel-Fisch et al., 2010; Catani et al., 2008) or may perhaps be explained by the personal victimization associated with child abuse that is not typically seen in out-group conflict-

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related violence (Dyer et al., 2013). This mechanism remains unclear and has been historically under-researched (Catani et al., 2008).

People with psychotic disorders have been found to be at greater risk of being violent than the general population (Witt et al., 2013); a relationship which is thought to be moderated by a multitude of factors such as heightened affect (Taylor, 1998), active symptomology type such as paranoia and delusional beliefs (Nestor et al., 1995), cognitive distortions and the increased likelihood of living in socially disorganised neighbourhoods (Nederlof et al., 2013), as well as poorer impulse control, substance misuse and the victimisation associated with a double psychiatric and forensic label (Witt et al., 2013). The prevalence rates of post-traumatic stress disorder (PTSD) for people with a psychotic disorder has been estimated to be 43% (Mueser et al., 2001) with a lifetime prevalence as high as 98% (Klewchuk et al., 2007) compared to 9% in the general population (Morrison et al., 2003). The high rates of trauma symptoms are thought to contribute to a sense of current threat and therefore increase the risk of pre-emptive violence (Spidel et al., 2010).

Despite the high prevalence of childhood trauma and the increased risk of violence in adulthood amongst people with psychotic disorders, the association between childhood trauma and adult violence in populations with psychotic disorders has been considerably under-researched. There are only two known quantitative studies at the time of writing. Sarkar et al. (2005) found that forensic patients with schizophrenia had significantly higher rates of childhood trauma and PTSD than non-forensic patients, and Spidel et al. (2010) found that a history of childhood trauma was associated with the perpetration of verbal and physical violence in adulthood in a first episode psychosis sample. These findings reflect what would be expected in individuals with psychotic disorders based on the childhood trauma literature in the general clinical and forensic population. However, there are a number of methodological limitations in the measurement and assessment of interpersonal adult violence, trauma and psychotic disorders in these studies. These include; a lack of standardised measures of violence as well as a neglect of measures that reflect the cascade of difficulties associated with violence risk, the exclusion of childhood neglect and other forms of childhood trauma such as conflict-related trauma, a lack of trauma sub-type analysis, a lack of a cumulative analysis of multiple traumatic experiences and a tendency to focus on categorical rather than continuum approaches to defining psychotic disorders which may not fully reflect the reality of the population.

This study therefore aimed to contribute to an under-researched area by exploring the association between multiple and accumulative childhood traumatic experiences and the risk of violence in adulthood in individuals with psychotic disorders. It also aimed to address some of the limitations of past research by including all psychotic disorders and multiple forms of childhood trauma, and using standardised measures of childhood trauma and the risk of violence perpetration. The context of Northern Ireland provided an opportunity to include childhood conflict-related trauma as well as childhood abuse and neglect. Conflict-related trauma was rife during the civil unrest known as the 'The Troubles' in Northern Ireland (Shannon et al., 2011) which spanned over 30 years, ending in 1998 with the Good Friday peace agreement, but with on-going sporadic episodes of community violence (Dyer et al., 2013). Based on past research it was hypothesised that both childhood abuse and neglect and childhood conflict-related trauma would be positively associated with the risk of violence. Furthermore, it was hypothesised that childhood abuse and neglect would have a stronger positive association with the risk of violence than childhood conflict-related trauma and that childhood abuse and neglect would negatively moderate the association between childhood conflict-related trauma and the risk of violence.

2. Materials and methods

2.1. Participants

Participants were patients from an inpatient forensic service, a community forensic service, an inpatient mental health service and a community mental health service who were selected using a convenience sample, based on the inclusion criteria: a) 18–70 years of age and b) a diagnosis of a psychotic disorder according to the DSM-IV by a psychiatrist involved in their care (namely schizophrenia, psychotic depression, bipolar affective disorder, schizoaffective disorder and psychotic episode not otherwise specified). All current patients were considered for inclusion by individual clinicians. Individuals were not approached if they had a history of traumatic brain injury, a neuro-degenerative disorder, an acute and severe disturbance of mental state, a limited understanding of English or if they had accessed a learning disability service in the past. This was assessed and decided by the appropriate clinician within each team.

2.2. Materials

Demographic information including number of hospital admissions, diagnoses and age of psychotic illness onset were collected. Three questionnaires were completed. The first was the Historical Clinical Risk assessment (HCR-20), a 20-item measure to evaluate the risk of violence requiring two days of training (Webster et al., 1997) completed by T.J.B and B.T. Administration involved quantitative scoring based on a clinical interview and a review of the case file as well as scores being independently rated. The HCR-20 has been reported to have high validity and high inter-rater consistency (RMA, 2007). The second questionnaires was the Child Trauma Questionnaire (CTQ), a 28-item self-report inventory (Bernstein and Fink, 1998) that assesses the severity of 5 types of trauma (physical, emotional and sexual abuse and physical and emotional neglect) as well as a measure to identify possible under-reporting (Pearson, 1997). The CTQ has a high test-retest value of .88 and the range of internal consistency is .8–.97 (Bernstein et al., 1994). The final questionnaire was the Troubles-Related Experience Questionnaire (TREQ), a 29-item self-report measure that assesses trauma related to The Troubles in Northern Ireland (Dorahy et al., 2007) by assessing exposure to serious events as well as the psychological impact of this exposure. Dorahy et al. (2007) found the internal reliability of the TREQ to be high and also found evidence of construct validity. The use in a measure of both a recording of traumatic events and an assessment of the subjective experience provides evidence of empirical grounding in a trauma model (Ehlers and Clarke, 2000).

2.3. Procedure

Ethical approval was granted by a local research ethics committee regulated by a statutory research governance framework. Written informed consent was obtained from each participant. The research was carried out in accordance with the latest version of the Declaration of Helsinki as revised in 1989.

3. Results

Out of 58 individuals who were approached by their clinical team, 41 agreed to participate from an inpatient forensic service ($n = 13$), a community forensic service ($n = 4$), an inpatient mental health service ($n = 3$) and a community mental health service ($n = 21$). Of the 41 participants only two declined to have their case