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Religiosity in young adolescents with auditory vocal hallucinations



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ABSTRACT

The current exploratory study examined the associations between auditory vocal hallucinations (AVH) and delusions and religiosity in young adolescents. 337 children from a population-based case-control study with and without AVH, were assessed after five years at age 12 and 13, on the presence and appraisal of AVH, delusions and religiosity. AVH status (persistent, remittent, incident or control) was examined in relationship to religiosity. Results demonstrated a non-linear association between AVH and religiosity. Moderately religious adolescents were more likely to report AVH than non-religious adolescents (O.R.=2.6). Prospectively, moderately religious adolescents were more likely to have recently developed AVH than non-religious adolescents (O.R.=3.6) and strongly religious adolescents (O.R.=7.9). Of the adolescents reporting voices in this sample (16.3%), more than half reported positive voices. Religious beliefs were often described as supportive, useful or neutral (82%), regardless of the level of religiosity, for both adolescents with and without AVH. Co-occurrence of AVH and delusions, and severity of AVH were not related to religiosity. The present findings suggest there may be a non-linear association between religious practices were adopted in response to AVH as a method of coping.

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1. Introduction

Auditory vocal hallucinations (AVH) occur relatively frequent in the general population in children, adolescents and adults, yet commonly disappear over time (Altman et al., 1997; Van Os et al., 2009; Bartels-Velthuis et al., 2011a, 2011b). Studies using large pediatric samples in England (5-15 year olds, Egdell and Kolvin, 1972; 11 year olds, McGee et al., 2000) and the Netherlands (7-8 year olds, Bartels-Velthuis et al., 2010) have found prevalence rates of AVH in children and adolescents varying from 8 to 9% (for a review see: Jardri et al. (2014)). In a proportion of these adolescents AVH were persistent two years later (27% in Dutch 15-16 year olds; De Loore et al., 2011) and five years later (23.5% in Dutch 12-13 year olds; Bartels-Velthuis et al., 2011b). The course of AVH over time depends on various individual and environmental factors (van Os et al., 2009). One of these factors might be religiosity, since several studies have demonstrated that religiosity is associated with a higher prevalence of psychotic experiences (Mohr

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http://dx.doi.org/10.1016/j.psychres.2015.12.014 0165-1781/© 2015 Elsevier Ireland Ltd. All rights reserved. et al., 2006), both in adults in the general population (Aird et al., 2010) and in adult patient samples (Getz et al., 2001; Suhail and Ghauri, 2010). Explanations for this association have ranged from using religion as a coping strategy (Mohr et al., 2006), through the notion that religion may promote distorted perceptions and distrust of others (Aird et al., 2010), to the idea that a connection with an omnipotent force (God) yields a conviction of 'super human' abilities (Suhail and Ghauri, 2010). The consensus in these notions is that religion may have both a positive and negative effect on mental health and well-being in adults (Pargament et al., 1998; Koenig, 2009).

Little is known about the association between AVH, delusions and religiosity during adolescence. There are studies that have examined the relationship between religiosity and other mental health aspects in adolescent samples, such as depressive episodes, anxiety, suicidal ideation, behavioural problems, and substance abuse (12–21 year olds, Dew et al., 2008). Reviews conclude that religion mostly has a positive relationship with mental health in children/adolescents (Dew et al., 2008; 10–20 year olds, Wong et al., 2010), yet some studies report a negative relationship (20 year olds, Exline et al., 2000) or none at all (e.g. Evans et al. (1996); for a review see: Dew et al. (2008)). One study reported a curvilinear relationship between religiosity and emotional problems (11–19 year olds, Meltzer et al., 2011). Adolescents with weakly held religious beliefs were more likely to have emotional problems in relation to adolescents with no or strongly held beliefs. Overall, there is some evidence for a relationship between religiosity and mental health during adolescence, yet the direction is still equivocal.

Several studies examined the association between religiosity and psychotic experiences in adult samples. Religious adults from the general population who experience and appraise their AVH within the context of their religion, tend to experience them more positively and less stressful compared to non-religious psychotic patients and non-religious healthy controls (Davies et al., 2001). In clinical samples, patients can report both positive (as a resource for coping) and negative (as an aggravation of psychopathology) influences of religion (Koenig, 2009; Cottam et al., 2011). The valence of religious influences on psychopathology has been related to outcomes (e.g. Shah et al. (2011)). For patients, negative religious coping in response to life stressors (indicative of a 'spiritual struggle') has been found to be related to increased suicidal ideation, depression and anxiety, whilst positive religious coping was related to decreased depression and anxiety (Rosmarin et al., 2013). Similarly, Mohr and colleagues (Mohr et al., 2011) reported that 83 percent of patients with psychosis found religion helpful, which was predictive of decreased negative symptoms and improved quality of life. Notably, the aforementioned studies were conducted in both Western (Britain, Davies et al., 2001; Switzerland, Mohr et al., 2006) and non-Western (India, Shah et al., 2011) countries.

Factors that have been identified as important for the course of AVH during childhood, are (amongst others) the co-occurrence of AVH with delusions (Smeets et al., 2012a,b) and the persistence of voices over time (Bartels-Velthuis et al., 2011b). AVH severity is positively associated with delusions (Bartels-Velthuis et al., 2012b), and compared to experiencing hallucinations or delusions in isolation, a combination of these experiences is more persistent and associated with more help seeking (Smeets et al., 2012a,b). Moreover, persistent and incident AVH during childhood in itself are also associated with more problem behaviour and worse school performance (Bartels-Velthuis et al., 2011b). It is both interesting and important to explore how religiosity is related to the course of AVH and the co-occurrence with delusions. If religion is indeed a source of comfort and hope for individuals who are faced with psychotic symptoms (Koenig, 2009; Rosmarin et al., 2013) and improves quality of life (Shah et al., 2011), adolescents reporting AVH might be more likely to report religious activity, as a method of coping. However, if religiosity is experienced negatively as a 'spiritual struggle', it could also aggravate psychopathology and instead be related to severity of AVH in adolescents.

Here, in a 5-year follow-up study of the case-control sample of 7- and 8-year-old children with and without AVH (Bartels-Velthuis et al. 2010), religiosity is examined in relation to the (i) frequency, (ii) course, (iii) co-occurrence with delusions, (iv) positivity, (v) usefulness, and (vi) severity of AVH. Given that previous studies have used heterogeneous methods of conceptualizing religiosity (Dew et al., 2008) and the literature indicates that (a) religiosity is best captured as a multidimensional concept (Meltzer et al., 2011), and (b) different degrees of religiosity have different effects on, for example, the degree of delusional ideation (Getz et al., 2001), the current study will conceptualize religiosity in both a continuous (more or less religious) and categorical (non-, moderate or strongly religious) manner. In line with these recommendations, religiosity will be assessed in terms of multiple facets (religious beliefs, activities and upbringing), whilst tapping into the conceptualisations of previous studies (Meltzer et al., 2011). Given that previous studies have yielded mixed findings

and that this study is, to the best of our knowledge, the first to examine these relationships in a young sample of non-clinical adolescents, our analyses are exploratory.

2. Methods

2.1. Subjects

The current study included 337 young adolescents, derived from a case-control sample of children with and without AVH (n=694; 50% with AVH) from a general population study on auditory hallucinations (Bartels-Velthuis et al., 2010). The original sample was composed five years earlier, from a survey on AVH in 3870 7- and 8-year-old children attending primary school in the province of Groningen, the Netherlands. Participants were thus assessed twice, at baseline (T0: age 7–8) and at 5-year follow-up (T1: age 12–13). Data from both time points were used.

T1 represented 56% (n=337) of the T0 sample with parental consent to follow-up (n=605). Participation at T1 was not associated with baseline AVH or control status. The mean age of the participants was 13.1 years (S.D.=0.5) and 46.7% of the participants were male. At T1, 55 adolescents reported AVH (16.3%), see also Table 1.

2.2. Procedures

Approval for the current study was obtained from the Medical Ethics Committee of the University of Medical Center Groningen. Parents who gave informed consent for being approached for their child's participation in the follow-up study were sent a notification letter via mail. In case of non-response, parents were reminded with a second letter, and if necessary they were later contacted by telephone.

Seven interviewers conducted the interviews at the adolescents home, in the absence of parents. The interviewers all followed a comprehensive training and booster sessions were arranged to prevent interviewer 'drift' (for more details see Bartels-Velthuis et al. (2011b)). To prevent bias, the interviewers were blind to adolescents' AVH status at baseline. Before the interviews took place, written informed consent was obtained by both the adolescents and one of their parents. In case parents or adolescents had questions as a result of the interviewing procedure, they could contact the research team.

2.3. Measures

2.3.1. Auditory vocal hallucinations

Consistent with studies investigating AVH (e.g. De Loore et al. (2011) and Fujita et al. (2015)), all adolescents were asked about the presence of AVH in the past five years: 'In the past five years, have you heard one or more voices that only you and no one else could hear?'. Those scoring positive on AVH in this period were interviewed with the Auditory Vocal Hallucination Rating Scale (AVHRS; Jenner and van de Willige, 2002; Bartels-Velthuis et al., 2012a), a structured interview to assess the characteristics and severity of AVH, in terms of frequency, duration, loudness, negative content, distress, anxiety, control, and interference with thinking and daily life. Scores range from 0 (not applicable) to 4 (most applicable). The AVHRS was developed in Dutch language for adult patients and in a later study (Bartels-Velthuis et al., 2010) the language was adapted for children/adolescents. The AVHRS has good inter-rater reliability, internal consistency and discriminative validity (Bartels-Velthuis et al., 2012a). All AVH variables were constructed in agreement with previous research (Bartels-Velthuis et al., 2010). A dichotomous variable was constructed indicating Download English Version:

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