



Trauma history characteristics associated with mental states at clinical high risk for psychosis



Debra A. Russo^{a,b}, Jan Stochl^{a,b}, Michelle Painter^a, Veronika Dobler^b, Erica Jackson^a, Peter B. Jones^{a,b,c}, Jesus Perez^{a,b,*}

^a CAMEO Early Intervention in Psychosis Service, Cambridgeshire and Peterborough NHS Foundation Trust, UK

^b Department of Psychiatry, University of Cambridge, Cambridge, UK

^c NIHR Collaboration for Leadership in Applied Health Research & Care, Cambridge, UK

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ABSTRACT

Traumatic experiences have been positively associated with both severity of attenuated psychotic symptoms in individuals at high risk (HR) for psychosis and transitions into psychotic disorders. Our aim was to determine what characteristics of the trauma history are more likely to be associated with individuals at HR. The Trauma History Screen (THS) was used to enable emphasis on number and perceived intensity of adverse life events and age at trauma exposure. Sixty help-seeking individuals who met HR criteria were compared to a random sample of 60 healthy volunteers. Both groups were aged 16–35 and resided in the same geographical location. HR participants experienced their first trauma at an earlier age, continued to experience trauma at younger developmental stages, especially during early/mid adolescence and were exposed to a high number of traumas. They were more depressed and anxious, but did not experience more distress in relation to trauma. Both incidences of trauma and age at which trauma occurred were the most likely predictors of becoming HR. This work emphasises the importance of assessing trauma characteristics in HR individuals to enable differentiation between psychotic-like experiences that may reflect dissociative responses to trauma and genuine prodromal psychotic presentations.

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1. Introduction

Psychosis has been linked with a history of adverse life events (Read et al., 2005; Morgan et al., 2007; Bendall et al., 2008; Bebbington et al., 2011; Fisher et al., 2010; Varese et al., 2012). Traumatic experiences, especially in childhood and early adolescence, appear to be related to psychosis in a dose–response fashion. The number of traumas has been positively associated with severity of attenuated psychotic symptoms in individuals at clinical high risk (HR) for psychosis and, eventually, transitions into frank psychotic disorders (Thompson et al., 2009; Bechdolf et al., 2010).

It is noteworthy that overall transition rates reported in different cohorts of individuals at clinical HR have consistently declined over the last decade (Yung et al., 2007). Subsequently, it has been suggested that HR mental states for psychosis may lack diagnostic specificity and predictive value. Indeed, the presence of psychotic-like symptoms in young people with disorders of anxiety and depression is more prevalent than previously considered (Wigman

et al., 2012a; Hui et al., 2013). Furthermore, psychotic-like experiences found in adolescent populations may act not only as markers for psychosis but also for other non-psychotic psychiatric disorders, such as depression and anxiety (Kelleher et al., 2012).

These findings raise the question about whether life stressors should exclusively be investigated as predictors of conversion to psychosis or also as potential contributing factors to HR mental states. In fact, early traumatic life events are common in people at HR (Tikka et al., 2013; Addington et al., 2013) who usually also present with significant morbidity and functional impairment regardless of whether they develop a full-blown psychotic disorder (Zimbron et al., 2012; Hui et al., 2013). Accordingly, addressing trauma in this population might help develop successful therapeutic interventions.

To achieve this ultimate goal it is important to obtain meaningful clinical information that should ideally consider the potential variability in both objective consequences and subjective perceptions after similar traumatic events among different individuals. This element has been neglected in the majority of measures assessing traumatic experiences, which usually survey a broad range of potential stressors and only ask for details of any events endorsed, including those that may not have been significantly distressing (Norris and Hamblen, 2004).

* Corresponding author at: CAMEO Early Intervention Services, Block 7, Ida Darwin Site, Fulbourn Hospital, Fulbourn, Cambridge CB21 5EE, UK. Tel.: +44 1223884360; fax: +44 1223884362.

E-mail address: jp440@cam.ac.uk (J. Perez).

The importance of assessing the degree to which the objective event was subjectively traumatic has been proposed by Spauwen et al. (2006) and Kelleher et al. (2013) with the inference that this may have an impact on risk for psychotic experiences (Kelleher et al., 2013). In concurrence, Wigman et al. (2012b) recommended using social stress as a proxy measure of sensitisation to traumatic experiences to aid understanding of any interactions between trauma and proneness towards psychosis. Furthermore, Addington et al. (2013) emphasised the need to detail both the age at which the trauma occurred and the frequency of trauma over time. Therefore, different combinations of trauma factors, such as perceived severity and frequency of sudden adverse life events, as well as age at trauma exposure, could help better understand different responses among individuals and the likelihood of developing a particular psychiatric manifestation (Carlson et al., 2011).

Another recognised limitation is the absence of matched healthy controls in studies investigating the relationship between trauma and psychotic symptoms (Thompson et al., 2009). This omission may also affect the conclusions to be drawn with regards to trauma prevalence.

By addressing the limitations of previous research, the aim of this study was to determine what characteristics of the trauma history are more likely to be associated with HR mental states in young people referred to mental health services in comparison with a sample of healthy volunteers recruited from the same geographical area. We particularly focused on the number and perceived intensity of adverse life events and age at trauma exposure.

2. Methods

2.1. Setting

CAMEO (<http://www.cameo.nhs.uk>) is an early intervention in psychosis service which offers management for people aged 14–35 years suffering from first-episode psychosis (FEP) in Cambridgeshire, UK. CAMEO also accepts referrals of people at HR. Referrals are accepted from multiple sources including general practitioners, other mental health services, school and college counsellors, relatives and self-referrals (Cheng et al., 2011).

2.2. Sample

A consecutive cohort of 60 help-seeking individuals, aged 16–35, referred to CAMEO from February 2010 to September 2012 met criteria for HR, according to the Comprehensive Assessment of At Risk Mental States (CAARMS; Yung et al., 2005). Referrals came to our offices via a number of different routes including self-referral, carers and relatives, schools and colleges, but mainly Primary Care. All individuals identified as HR for psychosis living and detected in Cambridgeshire and Peterborough were offered a systematic follow-up in the context of a prospective, naturalistic study called PAATH: Prospective Analysis of At-risk-mental-states and Transitions into Psychosis. Participants were followed-up for 2 years from the initial referral date. During this period, they were asked to attend subsequent interviews where they completed structured interviews and questionnaires. These questionnaires targeted different domains, such as socio-demographic characteristics, diagnosis, psychiatric morbidity, trauma history, substance use and functioning, among others.

In our sample, all individuals fulfilled criteria for the attenuated psychotic symptoms group. Seven individuals (11.7%) also qualified for the vulnerability traits group (individuals with a family history of psychosis in first degree relative OR schizotypal personality disorder PLUS a 30% drop in GAF score from premorbid level, sustained for a month, occurred within the past 12 months OR GAF score of 50% or less for the past 12 months). Intake exclusion criteria included: i) acute intoxication or withdrawal associated with drug or alcohol abuse or any delirium, ii) confirmed intellectual disability (Wechsler Adult Intelligence Scale – tested IQ < 70), or iii) prior total treatment with antipsychotics for more than 1 week.

During the same period (February 2010–September 2012), a random sample of 60 healthy volunteers (HVs) was recruited by post, using the Postal Address File (PAF[®]) provided by Royal Mail, UK. To ensure that each HR and HV resided in the same geographical location, 50 corresponding postcodes, matching the first 4/5 characters and digits of each recruited HR participant (e.g. PE13 5; CB5 3), were randomly selected using Microsoft SQL Server, a relational database management system, in conjunction with the PAF database. Each of these 50 addresses was sent a recruitment flyer containing a brief outline of the study, inclusion criteria and contact details. If this failed to generate recruits, a consecutive sample of postcodes

would be selected. This process was repeated until a match was recruited. An average of 100 flyers was sent to each postcode to recruit the 60 HV participants. HVs interested in the study could only participate if they were aged 16–35, resided in the same geographical area as HR participants (Cambridgeshire), and did not have previous contact with mental health services.

2.3. Ethical approval

Ethical approval was granted by the Cambridgeshire East Research Ethics Committee.

2.4. Measures

All participants were assessed with sociodemographic (age, gender, ethnicity and occupational status), trauma and clinical measures at the time of their referral to CAMEO. The assessments were carried out by senior research clinicians trained in each of the measurement tools.

HR participants were interviewed by senior trained psychiatrists working in CAMEO, using the Mini International Neuropsychiatric Interview (MINI), Version 6.0.0 (Sheehan et al., 1998), a brief structured diagnostic interview for DSM-IV Axis I psychiatric disorders. The Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987) for psychotic symptoms was also employed to capture the severity of positive symptoms (seven items), negative symptoms (seven items) and general psychopathology (16 items) in a 7-point scale, with higher scores indicating greater severity of illness.

To address the limitations of previous trauma measurement tools, the Trauma History Screen (THS; Carlson et al., 2011) was selected for this study. The THS was developed as a brief, easy to complete self-report measure of exposure to both high magnitude stressor events that could be traumatic (HMS) and events associated with significant and persisting posttraumatic distress (PPD). It assesses exposure to severe stressors which the authors define as sudden events that have been found to cause extreme distress in most of those exposed (HMS) and events associated with significant subjective distress that lasts more than a month (PPD) events. The authors propose that the theoretical rationale for including the specific stressor categories was that suddenness, lack of controllability, and a strong negative valence are all necessary, although not sufficient, characteristics for an event to cause traumatic stress (Carlson and Dalenberg, 2000).

The THS was developed to provide information about exposure to stressor events and about the severity and duration of emotional responses to stressful events. The reliability and validity of the THS have been demonstrated in clinical and non-clinical samples of homeless veterans, hospital trauma patients and their families, university students and adults and young adults from a community sample (Carlson et al., 2011). The reliability in these samples was good to excellent with median kappa coefficients of agreement for items ranging from 0.61 to 0.77. Construct validity was also supported by findings of strong convergent validity with a longer measure of trauma exposure and by correlations of THS scores between $r=0.73$ and 0.77 with PTSD symptoms.

This brief measure with a simple format and an easy reading level includes a gate question after the initial trauma checklist which is designed to only record details concerning events that were significantly distressing. The THS assesses trauma load, frequency and the distress caused by the traumatic events. It is a 13-item self-report measure that examines 11 events and one general event, including military trauma, sexual assault and natural disasters. For each event, respondents are asked to indicate whether the event occurred ('yes' or 'no') and the number of times something like this happened. For each event endorsed as emotionally troubling additional dimensions are assessed, including age when it happened, a description of what happened, whether there was actual or a threat of death or injury, feelings of helplessness and feelings of dissociation, a 4-point scale for duration of distress ('not at all' to 'a month or more') and a 5-point scale for distress level ('not at all' to 'very much').

The Beck Depression Inventory, Version II (BDI-II; Beck et al., 1996) and the Beck Anxiety Inventory (BAI; Beck and Steer, 1993) were used to assess depressive and anxiety symptoms respectively. BDI-II and BAI are widely used self-report instruments to assess depressive and anxiety symptom severity in the past 2 weeks. Each of them consists of 21 items rated on a 4-point scale from absent (0), mild (1), moderate (2) to severe (3). Composite scores (range 0–63 points) were generated by summing up individual items. Scores obtained from both measures were then used to analyse possible correlations with age at trauma exposure, number and intensity of traumatic events and associated distress.

2.5. Statistical analysis

All statistical analyses were performed using R software (R Core Team, 2013). For demographic comparisons between HR individuals and healthy volunteers Fisher's exact test was used. Overall number of traumas and age trauma occurred were compared using negative binomial regression. Poisson regression was used to compare individual traumas in both groups. *t*-Test was used for intensity of trauma comparisons. We calculated Pearson correlations to evaluate possible associations

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