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## Psychotic experiences and disability: Findings from the Collaborative Psychiatric Epidemiology Surveys

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### ABSTRACT

Psychotic experiences are associated with a number of poor clinical outcomes, including multimorbid psychopathology, suicidal behavior, and poor treatment response. We wished to investigate the relationship between psychotic experiences and disability, including the following domains: cognition, mobility, self-care, social interaction, role functioning, and days out of role. We used three nationally representative and racially/ethnically diverse samples of the general US adult population: the National Comorbidity Survey Replication (NCS-R), the National Latino and Asian American Survey (NLAAS), and the National Survey of American Life (NSAL). Multi-variable logistic regression analyses were used to assess the associations between lifetime psychotic experiences (visual and auditory hallucinatory experiences and delusional ideation; WHO Composite International Diagnostic Interview psychosis screen) and 30-day impairments in functioning across disability domains (using the WHO Disability Assessment Schedule II). In all three samples, models were adjusted for socio-demographics and co-occurring psychiatric disorders. In the NCS-R, models were also adjusted for chronic health conditions. Across all three studies, our adjusted models showed that people with disability had anywhere from about 1.5 to over 3 times the odds of reporting lifetime psychotic experiences, depending on the domain. This was true for each disability domain, except self-care in the NLAAS and in the NSAL. Psychotic experiences are markers of risk for disability across a wide range of domains. This may explain the elevated rates of service utilization among individuals who report psychotic experiences and supports the need to assess for and respond to psychotic experiences even in the absence of psychotic disorder.

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### 1. Introduction

Psychotic experiences are manifestations of psychosis that resemble frank hallucinations and delusions found in psychotic disorders, but are typically less intense, impairing, or persistent (Van Os et al., 2009). They can be ten times as prevalent as psychotic disorders, manifesting in approximately 10% of adults in the general US population (DeVylder et al., 2014a, 2014b). Extant research suggests psychotic experiences are useful indicators of general health. In addition to being associated with an increased risk for psychotic disorder (Dominguez et al., 2011), psychotic experiences are associated with increased risk for a wide variety of adverse health outcomes such as (non-psychotic) mental disorders (DeVylder et al., 2014a, 2014b; Kelleher et al., 2012; McGrath et al.,

2016; Wigman et al., 2012) and physical disorders (Moreno et al., 2013; Oh and DeVlyder, 2015), as well as suicidal behavior (DeVylder et al., 2015; Kelleher et al., 2013), and perceived need for help and treatment-seeking behaviors (DeVylder et al., 2014a, 2014b; Murphy et al., 2010; Oh et al., 2015a, 2015b).

While there has been extensive research on the relationship between psychotic experiences and mental and physical disorders, less is known about the relationship between psychotic experiences and functional disability in the United States. Two clinic-based studies (Yung et al., 2006; Wigman et al., 2014) and one general population study (Kelleher et al., 2015) have reported a relationship between psychotic experiences and poorer overall or 'global' functioning. However, it is important to examine the specific domains of functioning to more precisely understand potential target areas for intervention. To our knowledge, two studies have looked at specific domains of functioning, beyond global function: Yung et al. (2006) assessed social functioning in young people with psychotic experiences and found increased peer-

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and family-relationship difficulties; and Navarro-Mateu et al. (2017) analyzed the World Mental Health Surveys and found that respondents with psychotic experiences had elevated odds of reporting disability (specifically social and role impairment) across 19 countries, and these associations persisted after controlling for comorbid medical and mental disorders.

In the current study, we wished to look at a range of functional domains and their relationships with psychotic experiences using the World Health Organization (WHO) Disability Assessment Scale. Specifically, we investigated psychotic experiences as a marker of risk for disability in the following domains (1) social function, (2) role function, (3) cognitive function, (4) mobility, (5) self-care and (6) time out of role. We hypothesized that psychotic experiences would be associated with poorer functioning across all six domains.

## 2. Methods

### 2.1. Sample

We analyzed the Collaborative Psychiatric Epidemiology Surveys (CPES), which comprises three household surveys: (1) the National Comorbidity Survey Replication (NCS-R; Kessler et al., 2004), (2) the National Latino and Asian American Study (NLAAS; Alegria et al., 2004) and (3) the National Survey of American Life (NSAL; Jackson et al., 2004). These surveys were conducted between 2001 and 2003, and used a common core instrument, and similar multi-stage probability sampling strategies to achieve nationally representative samples of adults in the general population of the United States. The NCS-R is a nationally representative survey of 9282 individuals (predominantly White, reflecting the general population of the US), of which a random subsample ( $n = 2322$ ) completed the psychosis screen. In an effort to collect more robust data on racial and ethnic minority populations, two additional surveys were conducted. The NLAAS is a nationally representative sample of Latino Americans ( $n = 2554$ ) and Asian Americans ( $n = 2095$ ). The NSAL is a nationally representative sample of African-American households ( $n = 3570$ ), with Afro-Caribbean ( $n = 1621$ ) and White ( $n = 891$ ) respondents drawn from the same source neighborhoods, although Whites did not complete the psychosis screen. Taken together, these three surveys offer a more variegated and detailed portrait of the US population than any of three surveys alone. Sampling methodology of the CPES is described in detail elsewhere (Heeringa et al., 2004; Pennell et al., 2004). Socio-demographic comparisons across the three surveys can be found in prior studies (see DeVlyder et al., 2014a, 2014b). While all three surveys used a common core instrument, we analyzed each sample separately because problems arise from the CPES weights and psychosis screen when examining racial/ethnic groups across the combined data (DeVlyder, 2014).

Since this study focused on sub-threshold psychotic experiences, we excluded 23 individuals who self-reported ever having received a diagnosis of schizophrenia from a medical professional, given that there is already extensive empirical evidence that schizophrenia is associated with functional impairment. Further, participants were excluded from the analysis who were missing data for any of the variables of interest, resulting in smaller analytic samples (NCS-R  $n = 2287$ ; NLAAS  $n = 4617$ ; NSAL  $n = 4958$ ). The Role Functioning variable was not available in the NLAAS, and had additional missing values in the NLAAS and NSAL. Thus, analyses for Role Functioning domain in the NCS-R and NSAL were based on smaller samples (NCS-R  $n = 2176$ ; NSAL  $n = 4612$ ).

### 2.2. Measures

#### 2.2.1. Psychosis

Psychotic experiences were assessed using the WHO-CIDI 3.0 Psychosis Screen (Kessler and Ustun, 2004), which is a validated measure used internationally (see Kaymaz et al., 2012; McGrath et al., 2015).

Respondents were asked to report the lifetime occurrence of six psychotic experiences, including: (1) visual hallucinations, (2) auditory hallucinations, (3) thought insertion, (4) thought control, (5) telepathy, and (6) delusions of persecution. Endorsing at least one of these experiences constituted a positive endorsement of lifetime psychotic experiences. Responses were not considered a psychotic experience when occurring in the context of falling asleep, dreaming, or substance use.

#### 2.2.2. Disability

Disability was measured using the WHO Disability Assessment Schedule II (WHO-DAS II; Rehm et al., 1999), a 36-item general disability instrument which elicits the frequency and intensity of impairments over the past 30 days across the following six disability domains: (1) Cognition; (2) Mobility; (3) Self-care; (4) Social Interaction; (5) Role Functioning; and (6) Time Out of Role (See WHO-DAS II included in the online supplemental materials). Impairments could be due to health conditions, such as diseases or illnesses, other short/long-lasting health problems, injuries, mental or emotional problems, and problems with alcohol or drugs. Respondents were asked about the extent to which they experienced difficulties performing several activities, and could answer: none, mild, moderate, severe, and extreme/cannot do. Each domain was scored and standardized to a scale from 0 (no disability) to 100 (full disability); however, the most respondents reported having no disability. To deal with the skewness of the data, we dichotomized each domain to signify either having no disability or having any amount of disability (i.e. non-zero), as per previous studies using these data (e.g. Fortuna et al., 2010). Time out of role was defined as the number of days that one was unable to carry out usual activities because of any health condition, and was coded as a dichotomous variable reflecting at least one day out of role versus no days. The WHO-DAS II items measuring participation in society were not collected in the CPES.

#### 2.2.3. Mental and physical health problems

Psychiatric disorders included lifetime anxiety disorders (generalized anxiety disorder, panic disorder, social phobia, agoraphobia with and without panic attacks, post-traumatic stress disorder), mood disorders (major depressive disorder, dysthymia), substance use disorder (abuse and dependence), and alcohol use disorder (abuse and dependence). A single dichotomous variable was created to indicate the presence of any one of these psychiatric disorders over the course of one's lifetime. In the NCS-R only, data on chronic health conditions were available, and so a single dichotomous variable was created to indicate the lifetime presence of (1) any diagnoses from a doctor for asthma, hypertension, cancer, seasonal allergies, diabetes, epilepsy, heart disease, lung problems, peptic ulcer at any point in life; or (2) self-reports of arthritis, back or neck pain, headache, other chronic pain, or stroke at any point in life.

#### 2.2.4. Sociodemographics

Self-reported socio-demographic variables that had the potential to confound the analyses were included as covariates, per prior studies on psychosis (Kelleher & Cannon, 2011; Scott et al., 2006). In the NCS-R, race adjustments included Black, Asian, Latino, White, and other. In the NLAAS, race adjustments included Latino and Asian. In the NSAL, ethnicity adjustments included Caribbean Black American and African American. Other covariates included sex (Spauwen et al., 2003), age (18–29, 30–44, 45–59, 60+; Linscott and Van Os, 2013), marital status (single, married, previously married; e.g. Scott et al., 2006), nativity (US born, foreign born; Oh et al., 2015a, 2015b), education level (less than high school, high school, some college, college and beyond), and income-poverty ratio (e.g. Scott et al., 2006), which is defined relative to the federal poverty line (0 = poor, 1–2 = near poor, 3+ = non-poor; e.g. Kessler et al., 2005a, 2005b).

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