



Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Trauma and psychosis symptoms in a sample of help-seeking youth

Emily Kline ^{a,*}, Zachary B. Millman ^b, Danielle Denenny ^c, Camille Wilson ^b, Elizabeth Thompson ^b,
Caroline Demro ^b, Kay Connors ^d, Kristin Bussell ^d, Gloria Reeves ^d, Jason Schiffman ^b

^a Harvard Medical School, Department of Psychiatry at Beth Israel Deaconess Medical Center, 75 Fenwood Road, 5th Floor, Boston, MA 02115, United States

^b University of Maryland, Baltimore County, Department of Psychology, 1000 Hilltop Circle, Baltimore, MD 21250, United States

^c University of California Los Angeles, Semel Institute for Neuroscience and Human Behavior, 760 Westwood Plaza, Los Angeles, CA 90024, United States

^d University of Maryland School of Medicine, Department of Psychiatry, 701 West Pratt Street, Baltimore, MD 21201, United States

ARTICLE INFO

Article history:

Received 15 December 2015

Received in revised form 4 April 2016

Accepted 7 April 2016

Available online xxxx

Keywords:

Psychosis

Trauma

Clinical high-risk

Prodrome

Adolescence

ABSTRACT

Although childhood trauma is generally considered to be a risk factor for later development of psychosis, the influence of trauma on the specific presentation of psychosis symptoms in high-risk and first-episode samples remains unclear. The current study aims to investigate the association of trauma with psychosis and psychosis-risk symptoms among patients with early indications of psychosis as well as in a comparison group receiving mental health services for non-psychosis concerns. Participants ($N = 125$) were assessed for history of exposure to trauma using the KSADS-PL and psychosis-risk symptoms using the Structured Interview for Psychosis-Risk Syndromes (SIPS). Individuals were categorized as “clinical high risk/early psychosis” or “low-risk for psychosis” on the basis of SIPS criteria. The association of traumatic events with specific symptoms was explored within each group. Exposure to one or more traumatic events was more common within the early psychosis group (85%) relative to the low-risk group (65%). Within both groups, trauma significantly correlated with the severity of clinician-rated positive – but not negative, disorganized, or general – symptoms. Within the low-risk group, there was a significant association between violent traumas and heightened suspiciousness. Within the early psychosis group, both violent and non-violent traumas predicted elevated grandiosity. The prevalence of traumatic events within this adolescent and young adult clinical sample was high. Trauma history significantly predicted greater positive symptoms. The apparent influence of trauma exposure on specific symptoms was unique in each group.

© 2016 Elsevier B.V. All rights reserved.

1. Introduction

Childhood exposure to traumatic events is generally considered to be a risk factor for later development of psychosis (Read et al., 2005). A recent meta-analysis concluded that adverse events including sexual, physical, and emotional abuse, neglect, parental death, and bullying by peers strongly contribute to the risk of psychosis in adulthood, with a cumulative dose-response relationship between the number of trauma exposures and the likelihood of psychotic symptoms (Varese et al., 2012). These effects were found even when controlling for likely confounds such as genetic liability, comorbid psychopathology, substance use, and urban vs. rural environment (Varese et al., 2012). Further, repeated exposure to adversity and/or traumatic events during childhood appears to have profound, lifelong effects on mental and physical wellbeing within the general population (Anda et al., 2006) that may be additive for those with additional familial or neurodevelopmental vulnerability towards serious mental illness (Dvir et al., 2013).

Recent efforts have aimed to improve services for young people at risk for or in early stages of a psychotic illness (Fusar-Poli et al., 2013). Given the young age and still-emerging symptoms within at-risk and early psychosis samples, these individuals may constitute a uniquely informative group in which to study associations between trauma and symptom expression. Seventy to 100% of people at “clinical high risk” (CHR) across multiple samples report a history of traumatic experiences including physical abuse and neglect; sexual traumas; witnessing or being victimized by serious violence; and involvement in uncontrollable events such as accidents, war, and natural disasters (Bechdolf et al., 2010; Thompson et al., 2009; Tikka et al., 2013). Certain traumas (in particular, sexual abuse) have been found to exacerbate the likelihood of progression to psychosis over time (Bechdolf et al., 2010; Cutajar et al., 2010; Thompson et al., 2014). This observation is consistent with the notion that interpersonal traumas, that is traumas experienced as violations of relationships or social contracts, may be especially effective at provoking a physiological stress response, activating neural structures important for negative emotional processing (e.g., the amygdala), and disrupting overall mental health and social functioning (Amstader and Vernon, 2008; Arseneault et al., 2011; Jones and Fernyhough, 2007; Meyer-Lindenberg and Tost, 2012; Resnick et al.,

* Corresponding author.

E-mail address: ekline@bidmc.harvard.edu (E. Kline).

1997; Santiago et al., 2013). These processes may lead to a variety of psychiatric symptoms among otherwise typically developing youth; however, for those with preexisting vulnerability to psychosis, they may trigger or exacerbate the development of psychotic symptoms (Van Os et al., 2008).

Despite these established associations, the influence of trauma on the specific presentation of psychosis symptoms remains unclear. Trauma and stress reaction disorders share clinical features with the emerging psychosis construct, such as dysregulations in affect, cognition, and sleep. Further, posttraumatic thought intrusions relating to past experiences may be difficult to distinguish clinically from psychosis-related thought insertions and “loss of control” over internal experiences. Determining whether psychosis-like symptoms are better accounted for by traumatic experiences may be particularly difficult among adolescents, for whom illusions, hallucinations, and suspicions are common features of Post-Traumatic Stress Disorder (PTSD; Schlosser et al., 2012). Further complicating the issue, despite the high rates of traumatic events reported in CHR cohorts, the prevalence of diagnosable PTSD within this population (3–15%; Bechdolf et al., 2010; Lim et al., 2015; Meyer et al., 2005; Rosen et al., 2006; Woods et al., 2009) appears to be relatively typical for populations exposed to traumatic stress (Santiago et al., 2013). Understanding the relation between trauma and specific symptoms may help to inform best practices for differential diagnosis and trauma-informed treatment for this vulnerable population.

The current study aims to investigate the association of potentially traumatic events with early psychosis and psychosis-risk symptoms among youth receiving mental health services. Because the literature to date on this topic is scant, our investigations were exploratory rather than hypothesis-driven with the goals of exploring the prevalence of violent and non-violent traumas within a CHR/early psychosis group relative to a naturalistic clinical control group and investigating the relation between trauma exposure and specific symptom domains within the early psychosis construct.

2. Methods

2.1. Procedures

This study took place within the context of a longitudinal investigation conducted at the Strive for Wellness (SFW) clinic at the University of Maryland, Baltimore County (UMBC) and the University of Maryland Medical Center (UMMC). SFW is a specialty team of clinicians, researchers, and trainees focused on identification and treatment of individuals at CHR for psychosis. The clinic is embedded within the Maryland Early Intervention Program, a multi-institutional research/clinical/training collaborative established to improve the lives of individuals in the early phases of psychosis.

Study participation was open to any individual age 12–22 who was receiving mental health services. Youth were recruited from local hospitals, community health care providers, clinics (including a trauma clinic), and schools. Most clinician referrals to the study were intended as consultations for patients with some existing concern regarding psychosis risk symptoms; no participant had an existing diagnosis of a psychotic disorder prior to participation. Participants were told the study would involve a diagnostic evaluation and that the results would be offered to the youth's mental health-care provider. All participants provided informed consent prior to completing any study assessments (those under age 18 provided written assent and were required to have a legal guardian provide consent). All procedures were approved by the UMBC and UMMC Institutional Review Boards. The exclusion criterion for study enrollment was a guardianship status under the Department of Social Services for minors or any legal guardianship over adults. There were no other exclusion criteria and participants were eligible to participate in the study despite carrying any previous diagnoses (e.g., substance abuse).

2.2. Measures

Psychiatric diagnoses and trauma exposures were evaluated using the Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime version (KSADS-PL; Kaufman et al., 1997). The KSADS-PL is a semi-structured interview designed to generate DSM-IV diagnoses among youth. Respondents include parents and youth, separately interviewed by the same clinician. In the KSADS-PL PTSD screener, respondents are asked whether the youth has experienced any of several potentially traumatic events in their lifetime. Each item is scored dichotomously as yes/no. Number of exposures to a certain type of event or chronicity of exposure (e.g., witnessing domestic violence a single time vs. regularly throughout one's childhood) are unfortunately not captured by this scale. Resulting nominal scores represent the lifetime number of potentially traumatic event types the respondent has experienced. For this study, events endorsed during the KSADS-PL were also coded on the basis of whether they involved interpersonal violence (see Table 1). This coding procedure was applied due to evidence and theory suggesting that social stress in particular may be especially likely to exacerbate psychosis vulnerability.

Staff training for the KSADS-PL involved in vivo observation of an experienced diagnostician followed by co-rating of several interviews. Independent administration of the KSADS-PL was allowed when the trainee's diagnoses were in perfect or near-perfect agreement with the supervisors'. Cases were discussed during weekly team meetings to ensure consensus.

The Structured Interview for Psychosis-Risk Syndromes (SIPS; Miller et al., 2003) is a clinician-administered interview designed to determine the presence of psychosis and psychosis-risk syndromes. The SIPS provides criteria for three outcome categories: Low risk, in which no significant symptoms of psychosis are observed; presence of psychotic syndrome, in which a diagnosis such as schizophrenia is met; and CHR for psychosis. Based on the results of the SIPS, participants in the current study were classified into low-risk (“LR”) and “clinical high-risk/early psychosis” (referred to subsequently as “CHR/EP”) groups, with the latter group including any participant with SIPS-identified psychosis, schizotypal personality disorder, or a CHR syndrome. The decision to combine the CHR and EP groups for this study was made based on overall demographic and clinical similarity of these groups relative to the “LR” group. All participants, across both LR and CHR/EP groups, were receiving mental health services at the time of the study.

In addition to determining diagnostic categories, the SIPS also contains Likert-type ratings of symptom severity for 19 items rated 0–6 that fall into 4 symptom domains: positive (5 items), negative (6 items), disorganized (4 items), and general symptoms (4 items).

To achieve reliability of the SIPS, several raters attended in-person training provided by the SIPS authors. Raters who did not attend this training first rated several audio recordings of experienced SIPS interviewers. Once an intra-class coefficient of $\alpha = 0.75$ and a diagnostic agreement of $\kappa = 0.80$ was achieved, the trainees observed and co-rated at least two live interviews and then administered at least two supervised interviews. Raters could administer the SIPS independently when their reliability coefficients met the noted thresholds. For an ongoing reliability check, a sample of 10 audio recordings was selected for rating by the assessment team. Intra-class coefficients were $\alpha =$

Table 1
Violent and nonviolent trauma categories queried in the KSADS-PL.

Violent	Nonviolent
Victim of domestic violence	Receipt of traumatic news
Witness of domestic violence	Victim of car accident
Victim of physical abuse	Victim of fire
Victim of sexual abuse	Victim of natural disaster
Victim of other violent act	Victim of other accident

Download English Version:

<https://daneshyari.com/en/article/6822658>

Download Persian Version:

<https://daneshyari.com/article/6822658>

[Daneshyari.com](https://daneshyari.com)