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Prevalence and correlates of psychotic like experiences in a nationally representative community sample of adolescents in Ireland

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ABSTRACT

Adolescent psychotic like experiences (PLEs) are an important area of research, yet only a small number of community surveys have investigated their psychosocial correlates. This study presents the prevalence and correlates of three types of PLEs in a nationally representative community sample of 12–19 year olds in Ireland ($N = 5910$). Correlates are considered across five domains: demographic, stressful life experiences, emotional/behavioral problems, substance use, and personal resources. Auditory hallucinations were reported by 13.7% of participants, 10.4% reported visual hallucinations and 13.1% reported paranoid thoughts. Participants who had experienced two of the three PLEs were assigned “risk” status (10.4%; $n = 616$). Using binary logistic regression, PLEs were associated with a range of correlates across the five domains. Key correlates of risk status include depression (OR 4.07; 95% CI 3.39–4.88), low self-esteem (OR 4.03 95% CI 3.34–4.86), low optimism (OR 3.56; 95% CI 2.96–4.28), school misconduct (OR 3.10 95% CI 2.56–3.75), and high avoidance coping (OR 2.86 95% CI 2.34–3.49). These associations remained significant in a multivariate analysis. While correlates for each of the three PLEs were similar, there were some nuances in these patterns. Notably, demographic and substance use variables were the weakest groups of correlates. Personal resources (e.g. self-esteem, optimism and coping) have been poorly studied in the adolescent PLE literature and these findings provide important insights for future research and intervention design.

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1. Introduction

Psychotic like experiences (PLEs) are psychotic symptoms reported by members of the general population in the absence of illness i.e. a non-clinical psychosis phenotype (Kelleher and Cannon, 2011). The reported prevalence of PLEs among adolescents is 7.5% (Kelleher et al., 2012). A focus on this non-clinical psychosis population is important for several reasons. Firstly, a clinical continuum between PLEs and psychotic disorder has been demonstrated. Poulton et al. (2000) found that 11 year olds reporting psychotic symptoms during diagnostic interview were 16-times more likely to receive a psychotic illness diagnosis at age 26. In terms of specific PLEs, adolescent self-reported auditory hallucinations at age 14 are associated with a two- to five-times (females/males respectively) greater risk of non-affective psychoses at age 21 (Welham et al., 2009). Thus, adolescents experiencing PLEs can be considered at symptomatic increased risk for psychotic disorder. However, methodological limitations of the aforementioned studies regarding

specificity of PLEs for later adult psychiatric disorder have been highlighted, and non-psychotic outcomes are also common (Fisher et al., 2013).

Researchers have suggested that it may no longer be useful to extrapolate findings regarding early PLEs solely to psychotic disorders, but rather consider PLEs in youth as early markers for poor mental health more generally in adulthood (Fisher et al., 2013). PLEs are associated with a wide variety of non-psychotic psychopathology and they mark out risk for severe psychopathology and multi-morbidity (Kelleher and Cannon, 2012; Kelleher et al., 2012). The majority of adolescents who experience PLEs also report the experiences as distressing (Kelleher et al., 2015), and interventions to reduce such distress are needed.

Despite the recognition that adolescent PLEs are an important area of research, only a small number of community surveys have investigated their correlates. Thus a comprehensive understanding of the correlates of adolescent PLEs is important.

Regarding demographic factors, younger adolescents report a higher prevalence of psychotic symptoms than older adolescents (Kelleher et al., 2012). Certain studies report a higher prevalence of psychotic symptoms among male adolescents (Kelleher et al., 2008, 2012), but other studies report no gender differences (Scott et al., 2009). Additional demographic correlates include ethnic background (Laurens et al.,

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2012; Tolmac and Hodes, 2004) and blended or sole parent families (Scott et al., 2009). Family history of mental illness is one of the strongest risk factors for psychotic experiences in general population studies (Linscott and van Os, 2013), but this link requires clarification with adolescents. Known familial demographic factors associated with adolescent psychopathology including mother's education and father's employment (Bacikova-Sleskova et al., 2015; Dooley et al., 2015) also require investigation in the context of PLEs. In terms of stressful life events, PLEs are associated with experiences of bullying victimization (Campbell and Morrison, 2007; Lataster et al., 2006; Mackie et al., 2011) and perceived racism in adult samples (Karlsen et al., 2005; Veling et al., 2008). Other stressful life events commonly experienced by adolescents (e.g. bereavement) have been overlooked.

PLEs are associated with anxiety and depression (Armando et al., 2010; Mackie et al., 2011; Scott et al., 2006, 2009), externalizing behaviors (Downs et al., 2013) and both interpersonal violence and violence towards objects (Kinoshita et al., 2011). PLEs are also linked to substance use (Mackie et al., 2011), most notably adolescent cannabis use – both lifetime and recent (Henquet et al., 2005; Hides et al., 2009; Scott et al., 2009). Findings regarding alcohol use and adolescent PLEs are inconclusive (Scott et al., 2009; Van Os et al., 2009).

While further clarification is needed regarding many of above risk factors for adolescent PLEs, researchers have stressed the importance of examining an individual's strengths and resources, which can mitigate the likelihood of PLEs transitioning to psychotic disorder (Oh et al., 2014). Some studies indicate that emotional focused coping is associated with persistence of PLEs (Lin et al., 2011) and other studies report avoidant coping associations (Wigman et al., 2014). However, on balance, there is a dearth of literature considering personal resources including self-esteem, optimism, coping and personal competence, and whether they are significant correlates of adolescent PLEs.

Regarding types of PLEs, this study will examine correlates of auditory hallucinations, visual hallucinations and paranoid thoughts, due to their established predictive power for PLEs in adolescent samples (Kelleher et al., 2011). Of note, the assessment of auditory hallucinations has good predictive value not just for auditory hallucinations but for psychotic symptoms in general (Kelleher et al., 2011).

This study aims to advance knowledge in three ways. First, no study to date has examined such a range of factors from these five domains (demographic, stressful life experiences, emotional/behavioral problems, substance use, and personal resources) to establish correlates of adolescent PLEs. Second, this study considers variables pertaining to personal resources (self-esteem, optimism, competence, and coping) associated with other aspects of adolescent mental health, but largely overlooked in the adolescent PLE literature. Finally, previous research often only investigates predictors of a single PLE (e.g. hallucinations; Scott et al., 2009). However, theorists have called for the identification of relationships between different specific symptoms and predictor variables (Garety et al., 2007). This is particularly important in the case of adolescent PLEs where specific psychotic experiences appear to be quite distinct (Ronald et al., 2014).

2. Methods

2.1. Participants

Participants were drawn from a nationally representative post-primary sample of 6062 adolescents aged 12–19 years ($M = 14.95$; $SD = 1.62$) who participated in the My World Survey-Second Level (MWS-SL), a cross-sectional community survey of risk and protective factors of mental health (Dooley and Fitzgerald, 2012). The school

sampling framework was developed to reflect the national distribution of schools characterized as: disadvantaged and non-disadvantaged; the distribution of school gender composition (single-sex boys, single-sex girls, mixed gender); the distribution of schools in each Irish healthcare district and to include at least one school from every county in the Republic of Ireland. A sample of 6062 second-level students from 72 schools aged 12–19 years ($M = 14.94$, $SD = 1.63$) participated in the survey and 51% of the sample was female. Informed consent was obtained from all participants and their parents/guardians, with a participant response rate of 45%. Additional information regarding the procedures employed by the MWS-SL study including details on ethics, recruitment, and standardized protocol for survey administration in schools is available in a previously published article (Dooley and Fitzgerald, 2013).

2.2. Measurement of PLEs

Three questions regarding auditory hallucinations (“Have you ever heard voices or sounds that no one else can hear?”), visual hallucinations (“Have you ever seen things that other people could not see?”), and paranoid thoughts (“Have you ever thought that people are following or spying on you?”) were chosen from the Adolescent Psychotic-Like Symptom Screener (APSS) due to their reported predictive power for PLEs in the general population (Kelleher et al., 2011). Possible responses included “Yes, definitely”, “Maybe”, and “No”. PLEs were dichotomized as either present or not present; “Yes, definitely” was scored as 1, and “Maybe” and “No” were scored as 0. An a priori decision was made to assign “risk” status to those who had answered “Yes, definitely” to two of the three PLE questions, based on previous research regarding the predictive validity of two screening questions to predict PLEs in a diagnostic interview (Kelleher et al., 2011).

2.3. Demographic measures

All demographic questions were one item questions. Second Level School Cycle was dichotomized into Junior Cycle (Years 1 to 3) versus Senior Cycle (Years 4 to 6); Gender into male/female.; Ethnicity into “White” versus “Black”, “Asian”, “Irish Traveller” or “Other”; Intact parents into “parents married” or “living together but not married” versus other responses. Responses to “Has your mother or father ever had a mental health problem (for example, depression, alcohol, or drug addiction)” were dichotomized into “Yes” versus “No” and “Don't know”; Maternal Education into “Junior Certificate” (lowest level of education listed) versus other responses, and Paternal Employment into “Employed full-time/part-time” versus other responses.

2.4. Stressful life experience measures

Participants responded “Yes” or “No” to the following questions: “Have you been bullied?”, “Have you ever been treated unfairly because of your race or ethnic group?”, and “Has anyone close to you died in the last 12 months?”.

2.5. Emotional/behavioral problem measures

The depression subscale of the Depression, Anxiety and Stress Scale (DASS-21) was employed to ascertain whether participants had experienced depression. Using recommended cut-off scores (Lovibond & Lovibond and Lovibond, 1995), responses were dichotomized into normal or mild, versus moderate, severe or very severe depression. Participants were asked “Do you feel angry a lot” and responses were dichotomized into “No” versus “Yes” or “Sometimes”. School misconduct was assessed using 7 school-related items from the Behavioral Adjustment Scale (BAS; Brown et al., 1986) (e.g. cheated on an exam,

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