



## Self-reported attenuated psychotic-like experiences in help-seeking adolescents and their association with age, functioning and psychopathology



Martina Brandizzi <sup>a,c,\*</sup>, Frauke Schultze-Lutter <sup>b,1</sup>, Alice Masillo <sup>c</sup>, Andrea Lanna <sup>d</sup>, Martina Curto <sup>a</sup>, Juliana Fortes Lindau <sup>a</sup>, Andrea Solfanelli <sup>a</sup>, Giulia Listanti <sup>c</sup>, Martina Patanè <sup>c</sup>, Giorgio Kotzalidis <sup>a</sup>, Eva Gebhardt <sup>a</sup>, Nicholas Meyer <sup>f</sup>, Diana Di Pietro <sup>e</sup>, Donato Leccisi <sup>e</sup>, Paolo Girardi <sup>a</sup>, Paolo Fiori Nastro <sup>c</sup>

<sup>a</sup> Neurosciences, Mental Health and Sensory Functions (NESMOS) Department, Sapienza University of Rome, Faculty of Medicine and Psychology, Sant'Andrea Hospital, Via di Grottarossa 1035, 00189 Rome, Italy

<sup>b</sup> University Hospital for Child and Adolescent Psychiatry and Psychotherapy, University of Bern, Bolligenstr. 111, Haus A 3000 Bern 60, Bern, Switzerland

<sup>c</sup> Department of Neurology and Psychiatry, Sapienza University of Rome, Faculty of Medicine and Odontology, Rome 00156, Italy

<sup>d</sup> Department of Computer, Control, and Management Engineering "A. Ruberti", Sapienza University of Rome, Rome 00185, Italy

<sup>e</sup> Community Mental Health Service, ASL Rome H, 00041 Rome, Italy

<sup>f</sup> Institute of Psychiatry, King's College, 16 De Crespigny Park, SE5 8AF London, United Kingdom

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### ABSTRACT

**Objective:** Self-rated attenuated psychotic-like experiences (APLEs) are increasingly used to screen for ultra-high-risk (UHR) across all ages. However, self-rated psychotic-like experiences (PLEs), in particular perception-related ones, were more frequent in children and adolescents, in which they possessed less clinical significance. We therefore explored the prevalence of different factors of APLEs in help-seeking adolescents, and their relationship with age, functioning and psychopathology.

**Method:** As a part of the "Liberiamo il Futuro" project, help-seeking adolescents (N = 171; 11–18 years, 53% male) were screened with the 92-item Prodromal Questionnaire (PQ-92). A factor analysis was performed on the PQ-92 positive items (i.e., APLEs) to identify different APLE-factors. These were assessed for their association with age, functioning and psychopathology using regression analyses.

**Results:** APLEs were very common in help-seeking adolescents, and formed four factors: "Conceptual Disorganization and Suspiciousness", "Perceptual Abnormalities", "Bizarre Experiences", and "Magical Ideation". Associations with age and functioning but not psychopathology were found for "Perceptual Abnormalities" that was significantly more severe in 11–12-year-olds, while "Conceptual Disorganization and Suspiciousness" was significantly related to psychopathology.

**Conclusion:** In line with findings on PLEs, prevalence and clinical significance of APLEs, especially perception-related ones, might depend on age and thus neurodevelopmental stage, and may fall within the normal spectrum of experience during childhood. This should be considered when screening for UHR status in younger age groups.

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## 1. Introduction

Early detection of psychosis has become an important topic in psychiatry for which two main approaches have been developed: the ultra-high risk (UHR) approach and the basic symptom (BS) approach (Fusar-Poli et al., 2013; Schultze-Lutter et al., 2014a). However,

instruments assessing UHR criteria generally require additional training even of mental health specialists and several hours of clinicians' time.

### 1.1. Screening for ultra-high risk status using self-report questionnaires

Therefore, self-report screening instruments were developed to pre-select potential UHR patients for in-depth clinical assessment; one is the 92-item Prodromal Questionnaire (PQ-92) (Loewy et al., 2005; 2011) that is based on the Structured Interview for Psychosis-Risk Syndromes (SIPS; McGlashan et al., 2010; Miller et al., 2003). Concurrent validity of the PQ-92 was reported for different clinical samples: (1) patients from an early detection center (N = 113; 12–35 years) (Loewy et al., 2005); (2) patients from a secondary mental health service (N = 3,671;

\* Corresponding author at: Department of Neurology and Psychiatry, UOD Psicoterapia, Sapienza University of Rome, Faculty of Medicine and Odontology, Via Casal Dè Pazzi 16, 00156 Rome, Italy. Tel.: +39 0 6 4080 0589; fax: +39 0 6 4070 447.

E-mail address: [martina.brandizzi@gmail.com](mailto:martina.brandizzi@gmail.com) (M. Brandizzi).

<sup>1</sup> Joint first authors.

18–35 years) (Ising et al., 2012) with a cut-off “ $\geq 18$  positive symptoms” predicting SIPS-UHR status with 90% sensitivity and 90% specificity; and (3) adolescent patients from a general mental health clinic ( $N = 80$ ; 15–18 years) (Loewy et al., 2012) where both sensitivity (82%) and specificity (49%) were lower using the same cut-off, although psychosis-predictive validity of the PQ-assessed UHR status was comparable to that of the SIPS-assessed at one-year follow-up.

### 1.2. Age-related differences of self-reported (attenuated) psychotic symptoms

Most research on the PQ-92 has been carried out in mixed adolescent–young adult samples with little consideration of age-related differences. In a community sample of children and adolescents, age-related differences were reported for prevalence rates of self-rated psychotic-like experiences (PLEs). In particular, perception-related PLEs clearly decreased with age (from 21–23% of 11–13-year-olds to 7% of 13–16-year-olds), and increased in association with poorer socio-occupational functioning (Kelleher et al., 2012a; 2014) and with the presence of mental disorder (Kelleher et al., 2012a; Laurens et al., 2012). However, longitudinal studies of adolescents in the community (Dominguez et al., 2011; Smeets et al., 2012) suggest that persistence rather than prevalence of PLEs increases psychosis-risk. Yet, PLEs appeared to be poor estimates of clinician-assessed attenuated psychotic symptoms (APS), the main UHR criterion (Schultze-Lutter et al., 2011, 2014b). Thus, the content-valid assessment of APS might require specialized instruments such as the PQ-92. Furthermore, symptoms related to psychosis-risk were reported to cluster differently in children and adolescents compared to adults (Schultze-Lutter et al., 2012; Fux et al., 2013). From these findings, a need for research into the early detection of psychosis across the child and adolescent age-range was identified (Schimmelmann and Schultze-Lutter, 2012; Schimmelmann et al., 2013).

### 1.3. Aims and hypotheses

In order to address the need for age-related research in the study of self-reported attenuated psychotic-like experiences (APLEs), we examined the structure and prevalence of APLEs assessed with the positive symptom PQ-92-subscale, as a self-report estimate not of psychotic symptoms but of APS in help-seeking adolescents.

In addition to a perception-related factor, we expected a three-factor structure of delusion-like experiences similar to that reported for the Community Assessment of Psychic Experiences (CAPE) in 15–24-year-olds ( $N = 140$ ) (Yung et al., 2006), despite the PQ-92 assessing a broader spectrum of APLEs. Consistent with other PLE studies, a high prevalence of APLEs was expected, being highest in younger age groups, in particular with respect to perception-related APLEs. Additionally, an association of the presence and number of APLEs with poor functioning and psychopathology was hypothesized that might differ in strength between APLE-factors.

## 2. Materials and methods

### 2.1. Setting

Data were collected in six Child and Adolescent Neuropsychiatric Services (CANS) in the area of Roma H, Rome, Italy, between January 2012 and July 2013 as part of the early detection project “Liberiamo il Futuro” (LIF; Supplement material S1).

### 2.2. Sample

Inclusion criteria were: age between 11 and 18 years, residency in the Roma H area, and help-seeking from services for any psychological or behavioral problem. Of 384 eligible adolescents, 171 (44%) individuals

and their parents or guardians gave written informed consent to participate. Ethical approval was obtained from the local research ethics committee.

Participants were significantly older than refusers (mean  $\pm$  SD:  $14.8 \pm 1.9$  vs.  $14.3 \pm 1.8$ ; median: 15 vs. 14;  $U = 15186.0$ ;  $p = 0.005$ ), though the effect size was small (Rosenthal's  $r = -0.14$ ) with no gender difference (male: 53% of participants vs. 56% of refusers;  $\chi^2(1) = 0.164$ ;  $p = 0.381$ ).

### 2.3. Assessments

APLEs and self-reported negative, disorganized and general symptoms were assessed with an Italian translation of the PQ-92 that takes approximately 20 min to complete (Loewy et al., 2005). The translation was conducted by a trainee in psychiatry and a PhD student both fluent in English, with back-translation by a bilingual trainee in psychiatry. PQ-92 items were adapted from the SIPS and the Schizotypal Personality Questionnaire (Raine, 1991). Statements are rated true (1) or false (0); four subscales scores can be obtained by adding up affirmative responses: 1) 45 (attenuated) positive symptoms, i.e. APLEs (PQ-positive; Table 2), 2) 19 negative symptoms (PQ-negative; e.g., flat affect, social isolation), 3) 13 disorganization items (PQ-disorganization; e.g., odd behavior) and 4) 15 general symptoms (PQ-general; e.g., depression, functional deficits).

For a global rating of psychological, social and occupational functioning, we used the Global Assessment of Functioning Scale (GAF) (Hall, 1995) that had been part of DSM-IV (APA 1994) but was not included in the DSM-5 (APA, 2013). A cut-off of ‘60’ was considered to distinguish between poor and good general functioning (Bachmann et al., 2008; Schennach-Wolff et al., 2009). As additional functional outcome measures, two scales developed for the National Institute of Mental Health-funded multi-site NAPLS project (Cornblatt et al., 2007) were used: the GF:Social scale assessing social functioning by taking into account quantity and quality of peer and family relationships/conflicts including age-appropriate intimate relationships (Auther et al., 2006), and the GF:Role scale measuring role functioning by taking into account quantity and quality of school, work or homemaker performance (Niendam et al., 2006; Cornblatt et al., 2007). Both scales are rated between ‘1’ (extreme dysfunction) and ‘10’ (superior functioning); a cut-off of ‘6’ distinguishes between poor and adequate functioning (Schlosser et al., 2012; Carrion et al., 2013).

Past and present axis-I DSM-IV diagnoses were evaluated with the Kiddie-Schedule for Affective Disorders and Schizophrenia – Present and Lifetime (K-SADS-PL) version (Kaufman et al., 1997), a reliable semi-structured psychiatric interview.

### 2.4. Data analysis

Analyses were conducted using SPSS 20.0. Where Kolmogorov–Smirnov (K–S) tests for normal distribution were significant, non-parametric analyses of continuous data were preferred. Number and type of APLE-factors were determined using principal component analysis (varimax and oblimin method). Initially, the requirement of sufficient frequency of correlations  $>0.3$  was assured by inspection of the correlation matrix (Tabachnick and Fidell, 2007). Optimum number of factors was established using the Kaiser's method (Field, 2005) and a screen plot (Cattell, 1966).

Associations of the presence and number of APLEs with age, socio-demographic variables (i.e., gender, positive family history of any psychiatric disorder), functioning (i.e., binary: GF:Role, GF:Social and GAF) and symptomatology (i.e., any anxiety or depressive disorder, PQ-negative, PQ-disorganization, PQ-general) were independently explored by binary, multinomial and ordinal regression analyses with the presence/severity of APLE-factors as covariates. In ordinal regression analyses, the complementary log–log option was chosen assuming that higher categories are more probable.

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