



# The relation between childhood maltreatment and psychosis in patients with schizophrenia and non-psychiatric controls<sup>☆</sup>



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## ARTICLE INFO

### Article history:

Received 14 January 2014

Received in revised form 13 March 2014

Accepted 13 March 2014

Available online 3 April 2014

### Keywords:

Subclinical psychosis

Psychotic disorders

Childhood maltreatment

## ABSTRACT

Several lines of evidence suggest that childhood maltreatment is associated with an increased risk for both psychotic disorders and subclinical psychotic-like experiences in the general population. Few studies, however, have sought to examine whether the strength of this relationship is comparable across patient and non-patient groups. The present study sought to compare the strength of the association between childhood maltreatment and self-reported psychotic symptoms in 447 healthy adult volunteers and 184 stable outpatients with schizophrenia or schizoaffective disorder. Strong positive correlations between childhood maltreatment and self-reported symptoms were observed in both groups. Although patients scored significantly higher than controls on both history of childhood maltreatment and self-reported symptoms, the strength of the relationship did not differ between groups. These data provide strong support for etiological continuity between subclinical psychotic symptoms and psychotic disorders.

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## 1. Introduction

Childhood maltreatment is a major public health concern that has significant long-term consequences including an increased risk for poor physical health (Gilbert et al., 2009) and poor mental health outcomes (McLaughlin et al., 2010). The World Health Organization defines childhood maltreatment as all types of physical and/or emotional maltreatment and sexual abuse that results in actual or potential harm to the child and estimates that approximately one third of the general population experiences some form of maltreatment during childhood (Kessler et al., 2010). Several studies have demonstrated an association between childhood maltreatment and psychotic disorders and a recent review and meta-analysis of these studies (Varese et al., 2012) found that childhood adversity is substantially associated with an increased risk for psychosis with a population attributable risk of ~33%.

In recent years, considerable data have provided support for the existence of a continuous distribution of subclinical psychotic symptoms in the general population and several lines of evidence indicate that there is considerable etiological continuity between clinical and subclinical psychosis phenotypes (see Linscott and Van Os, 2013). This continuity is particularly pronounced for the relation between psychosis and childhood maltreatment (van Os and Linscott, 2012) even when genetic vulnerability to psychosis is taken into account (Arseneault et al., 2011). These data suggest that the experience of maltreatment during childhood may create a biological (Read et al., 2001) or psychological (Garety and Rigg, 2001) vulnerability for the development of psychotic symptoms along a continuum (Janssen et al., 2004).

In support of this continuum, Kelleher et al. (2013) recently demonstrated a dose–response relationship between childhood trauma and psychotic experiences in a large prospective cohort of adolescents followed over a 12-month period. Specifically, they found that the odds of psychotic experiences increased in line with increasing levels of bullying and physical assault. These data are consistent with findings suggesting that patients with psychotic disorders often have a more severe history of childhood maltreatment than healthy individuals (Kessler et al., 2010). To date, however, only a single study that we are aware of has sought to directly examine whether this difference in severity of childhood maltreatment directly contributes to the severity of self-reported psychotic symptoms across both patient and healthy control groups. Heins et al. (2011) examined the relationship between

<sup>☆</sup> Funding/support: This work was supported in part by grants from the National Institute of Mental Health to Dr. DeRosse (MH086756) and Dr. Malhotra (MH079800), the NSLIJ Research Institute General Clinical Research Center (M01 RR018535), the Advanced Center for Intervention and Services Research (P30 MH090590) and a Center for Intervention Development and Applied Research (P50 MH080173).

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severity of self-reported childhood maltreatment and severity of psychosis ranging from clinically significant psychotic symptoms to schizotypal symptoms across patients with psychotic disorders, their unaffected siblings and healthy controls. These authors found that self-reported histories of childhood abuse were associated with positive symptoms in a dose–response fashion across all three groups. However, the primary analyses in this study relied on a dichotomous measure of child abuse and thus, did not directly assess the strength of the relationship across the study groups. The aim of the present study was to examine whether the strength of the relation between childhood maltreatment and self-reported subclinical psychotic symptoms in healthy adult volunteers differs from the strength of the relation between childhood maltreatment and clinically significant psychotic symptoms in patients with schizophrenia or schizoaffective disorder.

## 2. Method

### 2.1. Participants

The present sample is comprised of 447 healthy adult volunteers (172 males, 275 females,  $M_{age} = 41.06 \pm 17.06$ ) and 184 stable outpatients with schizophrenia or schizoaffective disorder (127 males, 57 females,  $M_{age} = 40.98 \pm 11.07$ ). Healthy volunteers were recruited from the general population via word of mouth, newspaper and internet advertisements and posted flyers for an NIMH-funded study of subclinical psychosis (MH086756 to PD). Healthy participants were excluded from the study if they had an Axis I affective or psychotic disorder diagnosis, active or recent substance abuse or any disorder known to affect the brain. Approximately 6% of healthy participants screened for this project were excluded; most of whom met for a past affective disorder. Patient participants were recruited from the Zucker Hillside Hospital (ZHH), a division of the North Shore–Long Island Jewish Health System (NSLIJHS), for an NIMH-funded study on functional disability (MH079800 to AKM). Patient participants were excluded from the study if they had a psychiatric hospitalization within the preceding 6 months, met diagnostic criteria for current substance abuse (within the past month), or had a history of CNS trauma, neurological disorder or mental retardation. The patient sample used in the present study represents a subset of a larger sample and was selected based on the availability of data from the Community Assessment of Psychic Experiences (CAPE; Stefanis et al., 2002). The limited availability of CAPE data in the patient sample was due to the late addition of this measurement to the study. All participants provided written informed consent to a protocol approved by

the Institutional Review Board of the NSLIJHS. Specifically, patients provided consent for a study seeking to understand how genetic variability might contribute to differences in long-term prognosis while controls provided consent for a study seeking to understand how genetic variation might contribute to the normal expression of psychiatric symptoms.

### 2.2. Diagnostic assessments

Healthy participants were initially administered the Structured Clinical Interview for the DSM-IV, Non-Patient edition (SCID-I/NP) (First et al., 2002a) by Ph.D. or Master's level psychometricians, to rule out a past or present affective or psychotic disorder. Information obtained from the SCID was compiled into a narrative case summary and presented to two senior ZHH faculty. Absence of pathology was determined by consensus after the presentation of the narrative case summary and discussion of any relevant symptomatology. Patient participants were administered the Structured Clinical Interview for the DSM-IV Axis I Disorders, Patient edition (SCID-I/P) (First et al., 2002b) by Ph.D. or Master's level psychometricians. Information obtained from the SCID was supplemented by a review of medical records and interviews with family informants, whenever possible, and compiled into a narrative case summary. Diagnoses were then determined by a consensus among a minimum of three senior ZHH faculty, after a thorough review of the SCID and the corroborating information comprising the narrative case summary.

### 2.3. Assessment of childhood maltreatment

To assess the history of childhood maltreatment we utilized the 28-item Childhood Trauma Questionnaire (CTQ) (Bernstein et al., 2003). The CTQ is a 5-point Likert-type self-report questionnaire that measures several dimensions of abuse and neglect during childhood including physical, emotional and sexual abuse as well as emotional and physical neglect. Summing across all of these dimensions provides a total score that represents the severity of overall maltreatment experienced by an individual during childhood.

### 2.4. Assessment of subclinical and clinical psychopathology

All participants were assessed using the Community Assessment of Psychic Experiences (CAPE) (Stefanis et al., 2002). The CAPE is a 42-item, self-report questionnaire that measures three dimensions of

**Table 1**  
Characteristics of patients with schizophrenia or schizoaffective disorder and healthy volunteers included in the current study.

	Patients (N = 184)	Controls (N = 447)	Statistic	p value
Mean age (SD)	40.98 (11.07)	41.06 (17.06)	t = 0.07	0.95
Percent female	30.98	61.52	$\chi^2 = 48.77$	<.001
Race			$\chi^2 = 38.67$	<.001
White	80	311		
Black	68	81		
Other	36	55		
Mean CAPE (SD)				
Positive	29.90 (8.19)	23.46 (3.13)	U = 19,531	<.001
Negative	23.59 (6.83)	18.62 (4.04)	U = 22,816	<.001
Depressive	13.55 (3.96)	11.44 (1.97)	U = 28,560	<.001
Total	67.05 (16.02)	53.52 (7.88)	U = 19,311	<.001
Mean CTQ (SD)				
Emotional abuse	11.4 (5.56)	7.27 (3.57)	U = 22,413	<.001
Physical abuse	8.95 (4.77)	6.18 (2.21)	U = 25,328	<.001
Sexual abuse	8.40 (5.50)	5.66 (2.15)	U = 28,977	<.001
Emotional neglect	11.43 (5.50)	8.04 (3.87)	U = 25,580	<.001
Physical neglect	10.67 (3.04)	9.37 (1.42)	U = 31,117	<.001
Total	50.91 (17.49)	36.52 (9.88)	U = 18,293	<.001
Mean HRSD	11.59 (7.65)	n/a	n/a	n/a
Mean SANS (SD)	29.01 (12.54)	n/a	n/a	n/a
Mean BPRS positive	5.77 (2.86)	n/a	n/a	n/a

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