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Self-reported psychosis-like experiences in patients with mood disorders

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ABSTRACT

Background: Self-reported psychosis-like experiences (PEs) may be common in patients with mood disorders, but their clinical correlates are not well known. We investigated their prevalence and relationships with self-reported symptoms of depression, mania, anxiety, borderline (BPD) and schizotypal (SPD) personality disorders among psychiatric patients with mood disorders.

Methods: The Community Assessment of Psychic Experiences (CAPE-42), Mood Disorder Questionnaire (MDQ), McLean Screening Instrument (MSI), The Beck Depressive Inventory (BDI), Overall Anxiety Severity and Impairment Scale (OASIS) and Schizotypal Personality Questionnaire-Brief form (SPQ-B) were filled in by patients with mood disorders ($n = 282$) from specialized care. Correlation coefficients between total scores and individual items of CAPE-42 and BDI, SPQ-B, MSI and MDQ were estimated. Hierarchical multivariate regression analysis was conducted to examine factors influencing the frequency of self-reported PE.

Results: PEs are common in patients with mood disorders. The “frequency of positive symptoms” score of CAPE-42 correlated strongly with total score of SPQ-B ($\rho = 0.63$; $P < 0.001$) and moderately with total scores of BDI, MDQ, OASIS and MSI (ρ varied from 0.37 to 0.56; $P < 0.001$). Individual items of CAPE-42 correlated moderately with specific items of BDI, MDQ, SPQ-B and MSI (r_{ϕ} varied from 0.2 to 0.5; $P < 0.001$). Symptoms of anxiety, mania or hypomania and BPD were significant predictors of the “frequency of positive symptoms” score of CAPE-42.

Conclusions: Several, state- and trait-related factors may underlie self-reported PEs among mood disorder patients. These include cognitive-perceptual distortions of SPD; distrustfulness, identity disturbance, dissociative and affective symptoms of BPD; and cognitive biases related to depressive or manic symptoms.

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1. Introduction

Self-reported psychosis-like experiences (PEs) resemble positive psychotic symptoms and are experienced also by individuals without psychotic illness [1,2]. Numerous epidemiological studies have indicated that self-reported PEs are common in both the

general population [3–6] and patients with different mental disorders [7–10]. Individuals with depression and anxiety are known to more likely report PEs than healthy individuals [11,12]. Moreover, some studies have indicated that the severity of mental disorder correlates with frequency and persistency of self-reported PEs [13,14]. PEs have been associated with psychological distress [15,16] and higher risk for suicidal thoughts and behaviour [17,18].

Many studies indicate that self-reported subthreshold PEs are more prevalent than symptoms exceeding psychotic threshold [3,19,20]. The noticeable overlap of psychotic and mood disorders in genetic [21,22], neurobiological [23,24] and environmental risk

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factors [25] reflects a phenomenological overlap of psychotic and mood disorders on both clinical and subclinical levels [26]. However, frank psychotic symptoms are also common in mood disorders, and differences in their prevalence between diagnostic subgroups have been described. For instance, lifetime psychotic symptoms were reported by half of patients with bipolar I disorder (BD-1), twice as common than those with bipolar II disorder (BD-2), the latter having had psychotic symptoms only when depressed [27]. For definition of unipolar depression (UD) with psychotic features, there is a disagreement between the diagnostic classifications of the International Classification of Diseases 10th Revision (ICD-10) [28] and the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) [29], regarding relationship to severity of depressive symptoms. The majority of studies indicate that psychotic symptoms in UD tend to emerge in the more severe depressive episodes [30–32], but some studies revealed that depression with psychotic features was not necessarily associated with severity of depressive symptoms [33–36]. However, psychotic symptoms in UD were associated with an increased risk for relapse [33], greater morbidity and residual impairment [37] and worse outcome of psychotherapy [38].

Both PEs and dissociative symptoms are also among the core features of some personality disorders, including borderline (BPD) and schizotypal (SPD) personality disorders. Comorbidity of mood disorders with personality disorders is high [39,40]. Patients with UD appear more likely to have cluster A personality disorders and patients with BD cluster B personality disorders [41]. A higher occurrence of self-reported PEs and dissociative symptoms in individuals with personality disorders was associated with higher distress and worse treatment response [42–44]. Moreover, patients with self-reported features of BPD or SPD are more likely to develop a psychotic disorder [45,46].

Detecting of frank psychotic symptoms in patients with mood disorders is important because of treatment implications [47–49]. As mentioned before, subthreshold PEs in patients with mood disorders may have negative prognostic effect on their course and therefore detecting of PEs is also important, although their treatment implications are poorly understood. However, their clinical correlates are not well known.

The Community Assessment of Psychic Experiences (CAPE-42) has been shown to be a useful self-reported measure of positive, negative and depressive symptoms with good reliability and validity [50]. We investigated self-reported PEs measured by CAPE-42 in patients with UD and BD to determine the relationships between self-reported PEs and self-reported symptoms of depression, mania or hypomania, anxiety, BPD and SPD. We hypothesized that partial overlap of PEs and mood disorders symptoms can be observed at the level of self-reported features and the symptoms are associated with: (a) the severity of mood disorders and, (b) coexistent features of BPD and SPD. Therefore, we investigated correlations of the CAPE-42 positive scale with self-reported scales of anxiety, mood disorders, SPD and BPD on both total scores and item level and examined factors influencing the prevalence of self-reported psychotic symptoms in patients with mood disorder.

2. Methods

The Helsinki University Psychiatric Consortium (HUPC) study design, setting and patient sampling processes are presented in detail elsewhere [51,52], but are briefly outlined below.

2.1. Setting

The study was conducted in 10 community mental health centres, three psychiatric inpatient units and one day-hospital offering specialized secondary public mental health services in the

metropolitan area of Helsinki between 12.1.2011 and 20.12.2012. The catchment area (mean population 1139222 in 2012) encompasses the Helsinki metropolitan area, including the cities of Helsinki, Espoo, Vantaa, Kauniainen, Kerava, and Kirkkonummi where free-of-charge psychiatric secondary care services are provided to the residents of the area.

2.2. Sampling

Inclusion criteria were patients' age of over 18 years and provision of informed consent. Patients with mental retardation, neurodegenerative disorders and insufficient Finnish language skills were excluded. Stratified patient sampling selection was performed by identifying all patients within a certain day or week in a unit or by randomly drawing eligible patients from patient lists. Patients treated for psychotic disorders, neuropsychiatric disorders, anxiety disorders, eating disorders, BPD, or substance use disorders as lifetime principal diagnosis were excluded from this study. Of the 902 eligible patients with mood, neurotic or personality disorders, 372 refused to participate and 217 were lost for other reasons. Thirty-one patients with other lifetime diagnoses were excluded.

2.3. Clinical diagnoses

The validity of the clinical diagnoses assigned by the attending physicians was critically evaluated by the authors by re-examining all available information from patient records. The validated clinical diagnoses were based on the ICD-10. Lifetime principal diagnosis was assigned. We subtyped patients with BD into type I (BD-1), type II (BD-2) and not otherwise specified (BD-NOS) according to the DSM-IV.

2.4. Description of patients

Altogether 282 patients participated in the study. Their mean age was 42.2 ± 13.1 years, and 209 (74.1%) were female. Epidemiological characteristics of patients are presented in Table 1. There were 183 patients with UD (F32–F33) and 99 patients with BD (F31). Among patients with BD, 36 (36.3%) had BD-1, 55 (55.5%) BD-2 and 8 (8%) BD-NOS. Patients with BD-NOS and BD-2 were allocated to the same group. Nineteen patients with BD (20%) were hospitalized due to psychotic mania or psychotic depression (3 patients with BD-2 and 16 with BD-1). Among patients with UD, 14 (8%) had psychotic depression as a lifetime diagnosis.

2.5. Community Assessment of Psychic Experiences (CAPE-42)

The CAPE-42 is a self-reported questionnaire that measures lifetime psychotic experiences by using 42 items. The items measure symptoms in three main domains:

- Positive Symptoms (20 items);
- Negative Symptoms (14 items);
- Depression Symptoms (8 items).

Each item is rated at a 4-point Likert scale from 1 to 4 for both symptom frequency and the degree of distress experienced due to the symptom. Cronbach's alpha for CAPE-42 total score was 0.854. According to previous studies of the factorial structure of positive symptoms [53] we grouped items into 5 groups—grandiosity, paranoia, magical thinking, delusions and hallucinations.

2.6. McLean Screening Instrument (MSI)

The MSI is a ten-item questionnaire designed according to DSM-IV diagnostic criteria to screen for BPD [54]. It has been

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