



Research Paper

Psychiatric symptoms and related dysfunction in a general population sample



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ARTICLE INFO

Keywords:

Psychosis
Depression
Mania
Epidemiology
Cognitive functioning
Social functioning

ABSTRACT

Background: Along with the key clinical features of major psychiatric disorders such as psychosis, mania, and depression, these disorders are also associated with cognitive, social, and functional deficits. A growing body of evidence suggests that these disorders exist at the extreme end of a continuum of symptoms rather than as binary entities, so it is plausible that the associated cognitive, social, and functional deficits assume a similar pattern. Consistent with this approach, we sought to determine whether adults in the general population with psychiatric symptoms also demonstrate milder forms of the cognitive, social, and functional deficits that are often associated with the psychiatric disorders.

Methods: Using data from the Study of Resilience and Environmental Adversity in Midlife Health (STREAM), which includes survey responses of 811 individuals, we compared early academic achievement and self-reported social and functional outcomes between respondents who reported psychotic symptoms, manic symptoms, depressive symptoms, or no psychiatric symptoms (controls).

Results: Adults with psychotic symptoms had significantly poorer early academic performance ($p = .04$) and social and functional outcomes (self-reported marital status, $p = .021$, income, $p = .001$, and health, $p < .001$) than controls. Adults with depressive symptoms had significantly lower early academic performance and income and poorer health than controls (p 's = 0.033, 0.037, 0.013 respectively), and adults with manic symptoms also reported significantly lower rates of marriage than controls ($p = .006$).

Conclusions: The results are consistent with the continuum view of the etiology of psychiatric disorders in which psychiatric disorders are dimensional and experienced in varying degrees of severity across the general and clinical population. Importantly, the results highlight the potential impact of psychiatric symptomatology on functional outcomes in the population.

1. Introduction

In addition to the psychiatric symptoms associated with psychotic and affective disorders, they also entail disabling cognitive (Heinrichs and Zakzanis, 1998; Meijer et al., 2012; Taylor Tavares et al., 2003), social (Kupferberg et al., 2016; Morgan et al., 2017; Simon et al., 2007; Velthorst et al., 2016), and functional (Coryell et al., 1993; Goetz et al., 2007; Morgan et al., 2017) impairments that tend to persist even with treatment (Lewis, 2004; Simon et al., 2007; Taylor Tavares et al., 2003; Velthorst et al., 2016). While these deficits have been thoroughly studied in clinical populations, less is known about similar impairments in those experiencing psychotic and affective symptoms in the general

population. Prior studies indicate that this is a substantial group, with estimates of nonclinical psychotic symptoms ranging from 5.8%–16.3% (Henquet et al., 2006; McGrath et al., 2015), estimates of manic symptoms up to 37% (Kessler et al., 1997), and estimates of depressive symptoms ranging from 6.3%–11.8% (Judd et al., 1996; Rhee et al., 2014). These findings are suggestive of a continuum model of psychopathology, in which psychiatric disorders are not binary entities but exist at the most extreme end of a continuum of symptoms experienced in the general population.

If psychotic and affective disorders exist on a continuum rather than as binary entities, it is possible that the associated cognitive, social, and functional deficits follow a similar pattern, and that those in the general

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<https://doi.org/10.1016/j.scog.2018.08.001>

Received 23 May 2018; Received in revised form 8 August 2018; Accepted 9 August 2018

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population experiencing psychotic and affective symptoms also experience some level of impairment. Few studies, however, have examined the association between psychotic and affective symptoms and cognitive, social, and functional impairments in the general population. Two studies found that adults in the general population who experienced psychotic symptoms had fewer educational attainments (Johns et al., 2004), lower intellectual and cognitive functioning (Johns et al., 2004; Rossler et al., 2007), and poorer social (Rossler et al., 2007) and employment outcomes (Rossler et al., 2007) than adults in the general population without psychotic symptoms. Although evidence exists for social dysfunction in adults with subthreshold affective disorders (Goldney et al., 2004; Judd and Akiskal, 2003), the evidence is mixed for cognitive (Dotson et al., 2014; Simons et al., 2009) and functional deficits (Coryell et al., 1993; Goldney et al., 2004; Hybels et al., 2001; Judd and Akiskal, 2003; Judd et al., 1996; Zarate et al., 2000).

In the present study, we examined whether psychotic, manic, and depressive symptoms were associated with lower cognitive performance in adolescence, and social and functional deficits in adulthood in a general population sample of Israeli adults. We hypothesized that consistent with a continuum view of psychopathology, adults with psychotic, manic, or depressive symptoms would show patterns of cognitive, social, and functional impairment similar to those of their clinical counterparts. More specifically, we hypothesized that compared to adults without psychotic, manic, or depressive symptoms (controls), adults with psychotic symptoms would have poorer adolescent cognition, and that adults with psychotic, manic, and depressive would all have poorer social and functional outcomes than controls. We also hypothesized that individuals with affective symptoms would have more pronounced social and functional deficits than controls but fewer than individuals with psychotic symptoms. To the best of our knowledge, this is the first general population study to examine the associations of psychotic, manic, and depressive symptoms with cognitive, social, and functional deficits, as well as the first study to directly compare these associations across symptom domains.

2. Methods

2.1. Sample

This study uses data from the Study of Resilience and Environmental Adversity in Midlife Health (STREAM) cohort (Velthorst et al., 2015). The STREAM cohort consists of 811 participants between 34 and 44 years old that were randomly selected from 7000 individuals who were born and raised in inner-Jerusalem (Velthorst et al., 2015). After confirmation that there was no history of psychiatric hospitalization, participants were contacted for a telephone survey in 2007–2008 and were followed-up for a second round one year later. Survey topics included physical health (e.g. BMI, occurrence of migraines), psychiatric vulnerabilities (e.g. psychotic and depressive symptoms), socioeconomic status, lifestyle behavior (e.g. smoking, exercise), and other measures of daily experience (e.g. social contact, stress levels). Survey data was then retrospectively linked with data from national registry sources. For more detailed information on the data collection and survey methodology used in STREAM, see Velthorst et al. (2015).

2.2. Measures

2.2.1. Mental health

All questions assessing mental health variables were adapted from the Mini-International Neuropsychiatric Interview (MINI) (Sheehan et al., 1998): questions on psychotic symptoms were adapted from the Psychotic Disorders section; questions on manic symptoms were adapted from the Manic/Hypomanic Episode section; and questions on depressive symptoms were adapted from the Major Depressive Episode section. For specific questions, rating scales, and coding criteria, see Table 1.

2.2.1.1. Psychotic symptoms. Participants were asked about lifetime experiences of psychotic experiences (hallucinations and delusions (Table 1)). Those who experienced both delusions and hallucinations were grouped into a severe psychotic symptom category and those who experienced delusions or hallucinations were grouped into a mild psychotic symptom category. This classification of mild vs. severe by number of symptoms is consistent with prior studies on psychotic symptoms in the general population (McGrath et al., 2015).

2.2.1.2. Manic symptoms. Participants were asked about lifetime experiences of euphoric mania (e.g. increased excitement and energy) and dysphoric mania (irritability) (Table 1). Participants who experienced euphoric mania/dysphoric mania were grouped into a severe manic symptom category and those who experienced euphoric mania/increased excitement and energy or dysphoric mania/irritability were grouped into a mild manic symptom category.

2.2.1.3. Depressive symptoms. Participants were asked about depressive symptoms (despondency, anhedonia) in the past month (Table 1). Because there were fewer questions (and therefore less opportunity for a severe and mild group to emerge), we did not split the depressive symptom group by severity.

2.2.1.4. Controls. Participants who did not meet the criteria for the severe psychotic experience group, mild psychotic experience group, severe mania group, mild mania group, or depressive symptom group were included in the control group.

2.2.2. Adolescent scholastic achievement

School records come from the Jerusalem adolescent development study (JADs) (Ullman et al., 2012) for which the Jerusalem Municipality routinely collected 8th grade school records from all public school students from 1978 to 1988 ($n = 21,449$). All school grades range from 0 to 100 and the final data archive included report card grades for academic school subjects (e.g. math) as well as for nonacademic subjects (e.g. physical education). For this study specifically, grades for survey participants in Hebrew, math, geography, science, English (as a second language), gym, music, art, and handcraft were analyzed.

To examine overall adolescent scholastic achievement, scores in all subjects (Hebrew, math, geography, science, English as a second language, music, art, handcraft, and gym) were averaged into an overall composite score. To determine whether potential differences in scholastic achievement are driven by cognition (rather than behavior), we also averaged scores from academic subjects (Hebrew, math, geography, science, and English as a second language) into a core composite score and scores from nonacademic subjects (music, art, and handcraft) into a nonacademic composite score for comparison.

2.2.3. Midlife social and functional outcomes

We assessed social outcomes through self-reported marital status and functional outcomes through self-reported health and income.

2.2.3.1. Marital status. Participants were asked whether they were single, married without children, married with children, divorced/widowed without children, divorced/widowed with children. For the purpose of these analyses, responses were grouped into the categories of single, married, and divorced/widowed.

2.2.3.2. Income. Participants were asked to rate their total family income in relation to the average household monthly income in Israel (NIS 11,500 or ~3306 USD) on a scale from 1 to 5 (e.g. 1 = a lot below average, 2 = below average, 3 = around average, 4 = above average, 5 = a lot above average). For the purpose of these analyses, those who responded a lot below average and below average were considered below average, those who responded average were considered average,

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