



Sex differences in the association between childhood adversities and schizotypal personality traits

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ABSTRACT

Patients with psychosis report higher levels of adverse events in childhood. This relationship has not been extensively examined in healthy individuals who score highly on schizotypal personality traits. This study examined the association between different childhood traumas and psychosis-like traits in a general population sample, as well as differences in those links between men and women. Participants completed an online survey including measures of physical, emotional, and sexual abuse, and schizotypal personality traits. Results showed that the experience of emotional abuse was associated with a range of both positive and negative psychosis-like traits in both sexes. Sex differences emerged in the association between physical abuse and schizotypal personality traits. Although men reported more physical abuse in early life than women, this type of trauma was only associated with schizotypal traits in women and not in men. Additionally, women scored higher than men in sexual abuse; however, sexual abuse did not explicitly predict any schizotypal traits in the presence of the other two types of abuse. A simple linear or dose-response relationship between different types of trauma and psychosis-like traits was not supported. The importance of emotional abuse on schizotypy was highlighted in both sexes.

1. Introduction

Adverse experiences in childhood, such as physical, emotional, and sexual abuse, are associated with an increased risk of psychosis (Janssen et al., 2004; Read et al., 2005; Varese et al., 2012). Moreover, studies have reported a dose-response relationship between childhood traumatic experiences and the expression of psychotic symptoms (e.g., Muenzenmaier et al., 2015; Scott et al., 2007). Specific types of childhood trauma have also been associated with the development of different profiles of symptoms. For example, childhood sexual abuse has been linked to the development of auditory verbal hallucinations and physical abuse associated with both hallucinations and paranoid ideation (Bentall et al., 2012).

Evidence for the links between childhood abuse and psychosis is typically based on retrospective accounts of childhood experiences. Whilst reports of childhood abuse from individuals with psychosis are viewed as reliable by some (e.g., Fisher et al., 2011), others report low reliability across time for self-reports of childhood adverse experiences (e.g., Colman et al., 2016). Crucially, Colman et al. (2016) showed that the development of depression and psychological distress were

associated with an increasing likelihood of reporting a childhood adverse experience not previously reported by the same person. Additionally, increases in mastery (i.e., personal control over life outcomes) were associated with reduced likelihood of new reporting of a previously reported adverse experience (Colman et al., 2016). In other words, current mental state appeared to influence whether people do or do not report past traumatic experiences. Furthermore, the disclosure of a childhood traumatic experience could be influenced by a number of other factors in schizophrenia and psychosis. For instance, well-documented: memory deficits (e.g., Tyson et al., 2005); executive impairments, such as planning and problem solving (e.g., Holt et al., 2013); and reality distortions (e.g., Lee et al., 2013).

The continuum hypothesis of psychosis suggests that subclinical psychotic symptoms (or psychosis-like experiences), such as hallucinations (e.g., hearing voices) or delusions (e.g., believing that others have plans against one's self), are reported in healthy individuals (Johns and van Os, 2001; van Os et al., 2000; Verdoux and van Os, 2002). The assumption of this dimensional continuity of psychosis-like experiences in healthy people (also termed schizotypy) is that the experience of those symptoms would not be expected to be restricted only to patients

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with psychosis – even though these symptoms are mainly characteristics of psychotic disorders, such as schizophrenia. Additionally, it has been argued that the same factors, which increase the risk of psychosis (e.g., childhood abuse), also increase the risk of psychosis-like experiences (van Os et al., 2009). It is therefore important to assess the trauma-psychosis relationship in those who are healthy, but who experience some subclinical psychotic symptoms. One advantage of examining healthy participants is that recall of traumatic events is less likely to be affected by the condition itself, or by memory and executive function problems, and/or medication side effects. Another advantage would be to identify similarities in aetiological factors between patients with psychosis and those who score highly on schizotypy.

The relationship between trauma and psychosis-like experiences has received little attention in healthy individuals. In one of the very few studies assessing the link between childhood abuse and later psychosis-like traits in a community sample, Powers et al. (2011) found that *physical* abuse positively correlated with unusual perceptions, eccentric behaviour and social anxiety; *emotional* abuse was related to ideas of reference, excessive social anxiety, a lack of close friends, unusual perceptual experiences, and eccentric behaviour; while *sexual* abuse positively correlated with self-reports of eccentric behaviour. Powers and colleagues did not find any significant sex differences.

The role of sex differences in psychosis is well documented. In general, men with psychosis have been found to have an earlier age at onset (e.g., Eranti et al., 2013); more premorbid impairments, worse negative and less depressive symptoms (e.g., Abel et al., 2010); more severe cognitive deficits (e.g., Torniainen et al., 2011); and overall less favourable course of illness (e.g., Ochoa et al., 2012) than women. These sex differences have been mainly attributed to the protective role of estrogen, the main sex hormone in women. Moreover, it has been found that lower estrogen levels are associated with more severe symptoms (Seeman, 1996), and that women with psychosis have lower levels of estrogen than controls (Bergemann et al., 2007). Thus, it has been suggested that some degree of protection found in women could be accounted to this specific hormone. Although less is known about sex differences in subclinical psychosis, men have been found to score higher on negative psychosis-like traits than women and vice versa (Maric et al., 2003; Raine, 1992). However, no sex differences in subclinical psychosis were found in a relatively recent longitudinal study looking at age at onset, symptoms, course, and psychosocial outcome (Rossler et al., 2012). Rossler and colleagues suggested that sex differences in psychosis tend to appear at the high end of the psychosis continuum.

The pathways toward the development and experience of psychotic symptoms may also differ between the sexes. For example, sex differences have been reported in the association between early trauma and psychosis. Interestingly – bearing in mind that age at onset peaks at a later stage in women than men with psychosis, a recent study reported that even though women with schizophrenia spectrum disorder had a later age at onset than men, physical abuse in childhood predicted an earlier age at onset only in women (Kocsis-Bogar et al., 2018). Additionally, Fisher et al. (2009) reported that women who experienced psychosis were more likely to report sexual and physical abuse in childhood than controls; and that no such associations were found in men. Further, women have been reported to be more likely than men to develop Post Traumatic Stress Disorder (PTSD) following the experience of a traumatic event (Tolin and Foa, 2006). With regards to subclinical psychosis, Berenbaum et al. (2008) reported sex related differences in the relationship between childhood trauma and schizotypal traits in two studies. In their first study, they conducted telephone interviews on a large group of healthy participants and found that higher levels of schizotypal traits were associated with higher levels of childhood adversities in both men and women. In their second study, they conducted in-person assessments of individuals with elevated levels of schizotypal traits and found that childhood maltreatment was more strongly linked to schizotypal traits in men than women. In addition,

schizotypal traits were more strongly linked to PTSD characteristics in women than men (Berenbaum et al., 2008).

Given the paucity of research examining the role of childhood trauma and subclinical psychosis in healthy individuals, the current study investigated the links between different childhood traumas (i.e., physical, emotional, and sexual abuse) and psychosis-like personality traits in a general population sample. In particular, we were interested in the nature of sex differences in the experience of trauma and psychosis-like symptomatology.

2. Methods

2.1. Participants

Participants were recruited for an online survey via email (i.e., the Authors' institution staff email lists), social media (i.e. the Authors' institution news portal, Facebook, and Twitter), and a participant management system, which provided undergraduate psychology students ($n = 131$) with course credit for research contribution. No other participants were compensated for their time and everyone was encouraged to share the link with their friends and family. Four hundred and fifty five people attempted to complete the survey, of which 109 withdrew at various stages. The initial sample consisted of 346 participants, of which 26 were excluded because their responses were deemed unreliable (e.g. completing the survey overly quickly, repeatedly clicking the same response on every question). Of the 320 participants who completed the survey appropriately, 221 (69.1%) were women and 99 (30.9%) men. The mean age of the total sample was 28.24 ± 12.76 (range 18–75). Women and men participants differed in mean age (26.81 ± 12.09 versus 31.41 ± 13.69 : $t(169.23) = 2.88, p = 0.005$). The respondents reported their ethnicity as White British ($n = 162$), other white background ($n = 48$), Mixed background ($n = 11$), Asian ($n = 42$), Black African ($n = 21$), Black Caribbean ($n = 12$), other black background ($n = 4$), Chinese ($n = 3$), other ($n = 9$). Eight participants chose not to state their ethnicity. Demographic characteristics for men and women are included in Table 1. The study was approved by the first author's institution Health,

Table 1
Demographic data for women ($n = 221$) and men ($n = 99$).

	Women, n (%)	Men, n (%)
Employment		
Employed	60 (27.1)	51 (51.5)
Unemployed	7 (3.2)	3 (3)
Retired Student	3 (1.4)	4 (4)
Psychology	101 (45.7)	30 (30.3)
Other	50 (22.6)	11 (11.1)
Education		
High school	38 (17.2)	17 (17.2)
Vocational	2 (0.9)	2 (2)
College	91 (41.2)	31 (31.3)
Graduate	44 (19.9)	21 (21.2)
Master's	27 (12.2)	16 (16.2)
PhD	3 (1.4)	6 (6.1)
Professional degree	3 (1.4)	3 (3)
Other	13 (5.9)	3 (3)
Ethnicity		
White	138 (62.4)	72 (72.7)
Mixed	9 (4.1)	2 (2)
Asian	35 (15.8)	7 (7.1)
Black	26 (11.8)	11 (11.1)
Chinese	2 (0.9)	1 (1)
Other	7 (3.2)	2 (2)
No disclosure	4 (1.8)	4 (4)
Mental Health	50 (22.6)	21 (21.2)

Note. Mental health was assessed by a generic question where participants specified whether they have ever been diagnosed with a mental health condition by a professional in a yes or no response.

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