O-06-002

Schizotypal personality and childhood trauma as risk factors towards psychosis: epidemiological evidence from Qatar

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Objective: Qatar has undergone recent rapid urbanization. We estimated: (1) lifetime prevalence of psychotic experiences (PEs) [delusions only, hallucinations only, and both] in the Qatari population; (2) associations between PEs and both schizotypy (genetic predisposition) and childhood trauma. We hypothesised that lifetime prevalence of PEs would be associated with childhood trauma and schizotypy.
Methods: Adults (N = 1353) were interviewed. 1286 completed all PEs questions. Arabic and English interviews included Schizotypal Personality Questionnaire (SPQ), childhood trauma (terrifying experiences, beatings, abuse) and PEs. We used multinomial logistic regression with PEs as dependent variable testing associations with childhood trauma and schizotypy.
Results: 9.3% experienced hallucinations and delusions; prevalence (delusions only) 11.6%; (hallucinations only) 7.0%. Adjusting for age and gender, schizotypy was associated with mixed PEs [OR = 16.57, $p < 0.001$]; delusions only [OR = 4.25, $p < 0.001$] and hallucinations only [OR = 2.41, $p < 0.001$]. Childhood trauma events > 2 was associated with all profiles of PEs. A mixed profile of PEs was associated with odd behaviors [OR = 2.47, p = 0.001], abnormal ideas of reference [OR = 2.33, p = 0.008], odd beliefs and magical thinking [OR = 3.07, $p < 0.001$], unusual perceptual experiences [OR = 4.37, $p < 0.001$], and suspiciousness [OR = 1.91, p = 0.032]. Delusions alone were associated with odd beliefs and magical thinking [OR = 2.31, p = 0.005] and suspiciousness only [OR = 2.16, p = 0.017]. Hallucinations alone were associated with odd beliefs and magical thinking [OR = 3.23, p = 0.001] and unusual perceptual experiences only [OR = 2.81, p = 0.011].
Conclusion: PEs were associated with exposure to childhood trauma. Individuals reporting mixed profiles of PEs exhibited higher overall schizotypy associated with psychosis. Future studies may prospectively delineate potential risk of psychosis in individuals with history of childhood trauma.
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Emotion recognition and childhood trauma in individuals at clinical high risk for psychosis

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Objective: Social cognition is often impaired in people in early stages of psychosis, including in individuals at Clinical High Risk of psychosis (CHR). Recent studies have focused on facial emotion recognition (FER) deficits to investigate their possible relationship with increased liability for psychosis. Impaired FER is also a strong feature in individuals with history of childhood trauma (CT). CT is highly prevalent in CHR individuals and is associated with increased risk of transition to psychosis. In this study we investigated the relationship between FER and CT in a large sample of CHR individuals.
Methods: 345 CHR individuals and 66 healthy controls (HC) were recruited as part of an EU-funded multi-centre study (EUGEI). At 24-month follow-up, 65 CHR participants developed psychosis and 280 did not. Generalized regression models were used to analyse the relationship between the Degraded Facial Affect Recognition task (DFAR) and CT, measured with Childhood Trauma Questionnaire and Childhood Experience of Care and Abuse. Logistic regressions were used to analyze the relationship between transition to psychosis and the DFAR. A statistical threshold of $p < 0.05$ was used.
Results: Analyses revealed a significant increase in transition risk with increasing mistakes during the DFAR ($\chi 2 = 7.49$, $p < 0.001$). Irrespective of the group (i.e. CHR/HC), all individuals who experienced bullying performed better in the DFAR total [p = 0.03], happy [p = 0.049], and fear [p = 0.02] conditions than those who did not experience bullying. Individuals who experienced the death of a parent in childhood made more mistakes in the neutral condition [p = 0.008], and those who suffered emotional abuse performed worse in total DFAR [p = 0.01]. No other significant associations were found.
Conclusion: Emotion misattribution is associated with increased risk of transition to psychosis while, irrespective of the group, emotional abuse and death of a parent significantly affect FER ability. Being bullied does not negatively affect FER. This could have important implications for trauma treatment.
Policy of full disclosure: None.

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Neurocognitive deficits according to norms in adolescents with and without clinical high-risk states of psychosis

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Objective: In the early detection of psychosis, neurocognitive predictors have been suggested to enhance predictive accuracy of clinical high risk (CHR) criteria. While mainly sample-dependent means of adult samples were used so far, a recent study of an adult sample used neurocognitive deficits defined according to test norms in order to facilitate individual prediction. Yet, data on child and adolescent samples are missing.
Methods: We investigated the discriminative power of neurocognitive deficits defined according to norms in 8- to 17-year-olds.
Results: 160 CHR outpatients (AtRisk; mean age = 15.02 ± 2.20, 39% male), 270 non-psychotic inpatients (ClinS; mean age = 14.46 ± 2.43, 38% male) and 220 subjects of a general population sample (GPS; mean age = 13.91 ± 2.78, 48% male) had been assessed with a neurocognitive battery, including a verbal fluency (VF) test, the Digit-Symbol Test, TMT A and B, the Auditory Verbal Learning Test (AVLT) and the Subject Ordered Pointing Task. GPS were slightly younger than AtRisk and ClinS [Chi2(2) = 7.656, p = 0.022]; no differences were found with regard to gender and premorbid IQ. Compared to ClinS and GPS, AtRisk more frequently exhibited deficits according to norms in verbal memory (AVLT learning capacity; 22.4% vs. 10.7%; OR = 2.4, 95% CI 1.3–4.6) and VF (48.8% vs. 34.1%; OR = 1.8, 95% CI 1.1–3.0), while ClinS and GPS did not differ.
Conclusion: Partly in line with findings from adult samples, deficits in verbal memory and VF might be specifically associated with a CHR state in children and adolescents—even when compared to a more severely ill inpatient group. Yet, these findings need further examination in larger samples and longitudinal studies.
Policy of full disclosure: None.