

Editorial

Psychotic experiences: disadvantaged and different from the norm[†]

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**Summary**

Stress-induced alterations in how a person attributes meaning to internal and external stimuli may represent the first step in explaining how population ethnic minority–majority interactions affect mental health. Cross-context and diagnostic assumption-free research is required to elucidate

how the wider social environment interacts with personal characteristics to increase expression of psychosis.

Declaration of interest

None.

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The incidence of schizophrenia does not have a clear social class gradient and is not associated with poverty. There is, however, strong evidence for associations with childhood victimisation¹ and ethnic minority status.² Thus, victimised individuals and ethnic minority populations at risk of discrimination and exclusion have higher rates of service use for syndromes that in DSM are conceptualised as psychotic disorder. In addition, these populations also display higher rates of (subclinical) psychotic experiences, regardless of service use and traditional diagnostic boundaries.³

Although initially it was thought that experience of migration contributed to the observed increase in risk in ethnic minority populations, evidence suggests that the mechanism of risk may be different, pointing to the importance of the degree to which a person at risk of discrimination and exclusion is the exception in relation to the wider social environment.

To summarise the evidence that 'being the exception' rather than experience of migration *per se* may underlie the high rates of psychotic symptoms and disorders in ethnic minority populations at risk of discrimination and exclusion:

- the increase in risk persists into second-generation migrants without personal history of migration;²
- the increase in risk is also observed in stable ethnic minority populations that migrated centuries ago;⁴
- if migration involves a change from social exclusion to social inclusion, no increase in risk is observed;⁵
- there is progressively greater increase in risk with more visible minority status;²
- the risk for clinical psychotic syndromes in ethnic minority populations is lower in areas of high own-group density.^{6,7}

What mediates ethnic density associations?

The findings summarised above represent a good example of the 'relativity' of relative risks,⁸ as the increase in risk associated with ethnic minority status is contingent on social context – a phenomenon known as ecological effect modification. The fact

that the strength of the relative risk for psychotic disorder varies inversely with the prevalence of the risk factor in question – minority status – may be indicative of selection (e.g. individuals of ethnic minority most at risk form a specific cluster geographically) or causation (e.g. higher levels of own-group density confer a risk-decreasing buffering effect). It is difficult to distinguish between these two mechanisms, as this requires extensive and sophisticated cross-context comparisons that are difficult to conduct – particularly across cultural groups – given that schizophrenia represents a rare and variably defined mental disorder that typically is identified on the basis of service contact data. In this issue of the *Journal*, Das-Munshi and colleagues present fascinating evidence that density associations may in fact represent a combination of risk-increasing and protective mechanisms, using a subclinical psychosis outcome (defined as one or more psychotic experiences measured with the Psychosis Screening Questionnaire – PSQ) that was independent of service use and not prone to cultural bias in diagnosis.⁹ Their findings, summarised in Fig. 1, suggest that lower own-group density may result in greater exposure to psychosis-inducing social

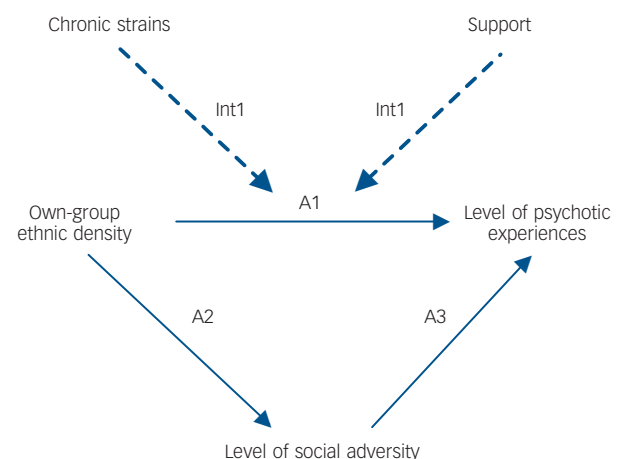


Fig. 1 Results presented by Das-Munshi *et al.*⁹

Three associations (A1–A3) and one interaction (Int1) were demonstrated across areas with different levels of own-group ethnic density. First, for a given individual who is a member of a minority ethnic group, the level of subclinical psychotic experiences was greater when living in a neighbourhood with lower own-group density, independent of social class, education and area deprivation (A1). Second, with decreasing own-group density, ethnic minority groups generally were more likely to report greater discrimination, poorer social support and more chronic strains (A2). Third, greater levels of racism, discrimination, chronic strains and difficulties, and lower level of social support, were associated with previous year psychotic experiences (A3). Finally, the protective effect of higher own-group density may be reduced in people experiencing chronic strains, and enhanced in people reporting high levels of practical or confiding/emotional support (Int1).

[†]See pp. 282–290, this issue.

adversity, and that although a risk-buffering effect of higher own-group density exists, this may be moderated by the level of strains and supportive relationships a person has.

What outcome do psychotic experiences represent?

The findings presented by Das-Munshi *et al* differ from previous work in one important aspect, namely the outcome under study. Psychotic experiences as measured by the PSQ are not 'schizophrenia light'. Rather, they represent a dimensional phenotype indexing aberrant attribution of salience that is prevalent in the general population (prevalence 8%),³ substantially more prevalent in common mental disorder (anxiety and depression; prevalence 30%)¹⁰ and universal in psychotic disorder. In the general population, psychotic experiences predict an increase in risk for transition to psychotic and (to a lesser degree) non-psychotic disorder at an annual rate of 0.6%;¹¹ in common mental disorder, they have a negative impact on course and outcome (see Appendix).^{10,12} Thus, the increase in risk for psychotic experiences associated with lower own-group density in part may mediate the association with schizophrenia demonstrated in previous work.^{6,7} However, Das-Munshi *et al*'s findings also suggest that the impact of lower own-group density extends dimensionally to an extended psychosis phenotype of aberrant salience with relevance for (a) behavioural expression of risk in the general population and (b) course and outcome of common mental disorder. The findings therefore concur with recent meta-analytic work, for example in the area of childhood victimisation,¹ that indicates that the environment may have an impact on dimensional expression of a specific domain of psychopathology that extends across traditional disorder boundaries.

Conclusions

The findings presented by Das-Munshi *et al* provide, for the first time, an indication of how the wider social environment, indexed by variation in own-group ethnic density, may interact with personal characteristics in predicting alterations in mental health in disadvantaged populations. By moving away from traditional diagnostic categories that are lacking in validity, more room is created for active interpretation of the data. How communities interact with minority ethnic groups has public health implications; however, the relative protective effect of being a member of the majority group still depends on the quality of supportive relationships one has. Stress-induced alterations in how a person attributes meaning to internal and external stimuli may represent the first step in explaining how population ethnic minority-majority interactions affect mental health.

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Appendix

Extended psychosis phenotype: meta-analytic findings^{3,11,13} to date

- Prevalence around 7.5%, incidence around 2.5%; however, a substantial amount of the considerable heterogeneity in rates of psychotic

experiences across studies is due to study method, cohort and design factors

- Associated with family history psychotic disorder, childhood trauma, cannabis use, ethnic minority status, unemployment, low income, younger age
- Prevalent in disorders of anxiety and depression predicting worse outcome and a more psychotic disorder risk profile as well as demographic profile
- The 2- to 5-year persistence rate is about 20–30%
- Persistence is influenced by genetic and environmental factors
- Psychotic experiences predict onset of later psychotic and (to a lesser degree) non-psychotic disorder and admission to hospital (at a rate of 0.6% per year), particularly if persistent
- Other factors associated with transition to psychotic and non-psychotic disorder are: baseline severity of psychotic experiences, level of admixture with affective dysregulation and motivational impairment, social functioning and coping level.

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