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Authors

Ruiz-Yu, Bernalyn

Novacek, Derek M

Bearden, Carrie E

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Editorial: Psychotic-like Experiences: Bolstering Protective Factors in Marginalized Youth

Bernalyn Ruiz-Yu, PhD,

Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles.

Derek M. Novacek, PhD,

Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles; Desert Pacific Mental Illness Research, Education, and Clinical Center, VA Greater Los Angeles Healthcare System, California.

Carrie E. Bearden, PhD

Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles.

Racial disparities in the prevalence and clinical characteristics of psychotic disorders are well documented. Psychotic-like experiences (PLEs) are subthreshold psychotic symptoms in the absence of overt psychotic illness that are nevertheless distressing and associated with negative outcomes. In the general population, racially and ethnically minoritized individuals are more likely to report PLEs compared to White individuals, consistent with the disparities in psychosis diagnosis.¹ However, our understanding of the factors driving observed differences in PLEs is limited. Most of the published research on PLEs has been in adolescents and adults, whereas less is known about racial/ethnic differences in PLEs in children. A better understanding of the factors that drive the racial/ethnic differences in these experiences could inform development of culturally responsive, preventative interventions to mitigate disparities.

The study that is the focus of this editorial advances our understanding of PLEs in children by demonstrating that experiences of discrimination partly explain the observed differences in PLEs among racial/ethnic groups. Here, we review the main findings of Karcher and Klaunig *et al.*² and discuss the implications for research, treatment, and mental health policy.

Karcher and Klaunig *et al.*² examined PLEs among racial/ethnic groups using the Adolescent Brain Cognitive Development (ABCD) cohort (n = 10,839), a population-based prospective study of children aged 9 to 10 years at the time of this assessment. ABCD is the largest long-term study of child health and brain development in the United States, and as such is designed to reflect the demographic diversity of the United States. PLEs were measured by the Prodromal Questionnaire–Brief Child Version (PQ-BC), for which Karcher *et al.*³ previously demonstrated construct validity and good psychometric properties in

Correspondence to Carrie E. Bearden, PhD, A7-460 Semel Institute, Los Angeles, CA 90095; cbearden@mednet.ucla.edu.
Author Contributions

Writing – original draft: Ruiz-Yu, Novacek, Bearden

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children aged 9 to 10 years, making this measure developmentally appropriate for the study population. Race/ethnicity was recorded based on caregiver report. The researchers gathered data on experiences of discrimination (EOD) in the previous 12 months, social support as measured by youth report of number of close friends, English language ability, financial adversity, and adverse childhood experiences on the PhenX Adverse Life Events Scale. Mediation analyses examined whether EOD potentially mediated the association between race/ethnicity and PLEs. Further analyses examined whether social support moderated the relationship between EOD and PLEs. The key findings of the study are that: (1) Black, Hispanic, and multiracial/multiethnic participants have higher mean PLE scores than Asian or White participants; and (2) higher PLEs were associated with more experiences of discrimination; however, this effect was attenuated by increased social support.

As the primary study was not designed to examine racial/ethnic differences in PLEs in youth, there are inherent limitations in this secondary analysis. However, the large sample size and representativeness of the cohort offer a unique opportunity to investigate sociocultural factors contributing to the experience of PLEs in youth. In addition, experiences of discrimination are one possible proxy for racism in the United States; it would be worthwhile for future studies to use measures that more directly quantify structural racism.⁴ Finally, a follow-up investigation of the impact of EOD, experience of PLEs, and other factors investigated here on prospective mental health outcomes in this cohort would be a valuable future contribution to the field.

There is a growing scientific effort to understand the determinants of racial disparities in psychosis. A recent article discusses structural racism as a fundamental cause of psychosis, conferring risk at multiple levels of analysis.⁵ Neighborhood-level factors, collective trauma, and individual-level social disadvantages create cumulative stressors that alter neurobiology, increase perinatal complications and genetic vulnerability, leading to heightened risk for psychosis in minoritized groups. As demonstrated by Karcher and Klaunig *et al.*,² discrimination plays a role in the development of psychotic-like experiences and symptoms. This offers a model for how researchers can empirically investigate social determinants of health. More empirical research is needed to identify targets of preventative interventions at both the individual and systems levels. These disparities have also sparked conversations about the need to promote equity in mental health services for youth at risk for psychosis.⁶

Several clinical, policy, and research implications stem from the findings of this study. Primarily, given that this study involved a non-help seeking population, it highlights the importance and relevance of early intervention, which includes reinforcing protective factors in youth vulnerable to the development of a mental illness. The findings also highlight the potential effects of social factors and experiences of discrimination on future mental health outcomes. Taken together with previous research demonstrating that poor perceived social support is associated with worse mental health outcomes,⁷ this study emphasizes the value of bolstering social support in youth that may be at risk because of having a minoritized status. One way this can be targeted is through building self-advocacy skills in youth, such as empowerment coping strategies, as previous research has noted the protective potential of this skill in youth experiencing subthreshold psychosis symptoms.⁸ Moreover, for clinicians, this study offers a reminder of the role of provider bias in the clinical encounter. As the

authors suggest, it is important that providers are mindful of the impact of societal factors when conducting psychological assessments with individuals from minoritized groups, so as not to overpathologize the experiences of these individuals. In addition to Karcher and Klaunig *et al.*'s² suggestion that clinicians and researchers seek out awareness of their potential bias through education and practicing cultural humility, they further suggest that clinicians and researchers consider objective measures of bias (eg, Implicit Association Task), to facilitate acknowledgement of ones' own biases, along with continual reflexivity in one's practice. Equally critical is active attention to ensuring diverse representation among clinical teams.

At a policy level, this study provides further evidence in support of the existing need to strengthen minoritized communities with the aim of targeting risk for serious mental illness at a national level. Policies that promote racial equity (eg, in education, health care, and housing) for historically marginalized communities will go a long way in reducing the cumulative stressors that are detrimental to mental health. Furthermore, this study sets up initial evidence and justification for future research that can help clarify the ways in which racism affects mental health outcomes in the United States. Longitudinal investigations that delineate ways in which structural and everyday racism confer risk for psychosis are warranted. Researchers can also aid in the development of culturally responsive interventions that enhance social support and other culturally sanctioned protective factors to mitigate the harms of racism at the individual level.

It is imperative that clinicians, researchers, and policymakers address the unmet mental health needs of marginalized communities. This new work from Karcher and Klaunig *et al.*² presents clear data about the impact of discrimination on risk for serious mental illness in Black and Hispanic children. Future work should continue to elucidate the mechanisms by which structural racism impacts mental health to guide evidence-based clinical and policy interventions.

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Diversity & Inclusion Statement:

One or more of the authors of this paper self-identifies as a member of one or more historically underrepresented racial and/or ethnic groups in science. One or more of the authors of this paper self-identifies as a member of one or more historically underrepresented sexual and/or gender groups in science. We actively worked to promote sex and gender balance in our author group. We actively worked to promote inclusion of historically underrepresented racial and/or ethnic groups in science in our author group. While citing references scientifically relevant for this work, we also actively worked to promote sex and gender balance in our reference list. While citing references scientifically relevant for this work, we also actively worked to promote inclusion of historically underrepresented racial and/or ethnic groups in science in our reference list. The author list

of this paper includes contributors from the location and/or community where the research was conducted who participated in the data collection, design, analysis, and/or interpretation of the work.

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