

## Parental education

### Introduction

Any association of low parental education with a higher risk for bipolar disorder has been largely inconsistent. This topic outlines the evidence for low parental education as a risk factor for bipolar disorder, however the results may reflect the effects of other influencing factors rather than parental education itself.

### Method

We have included only systematic reviews (systematic literature search, detailed methodology with inclusion/exclusion criteria) published in full text, in English, from the year 2010 that report results separately for people with a diagnosis of a bipolar disorder or related disorders. We also included reviews of psychotic symptoms. Due to the high volume of systematic reviews we have now limited inclusion to systematic meta-analyses. Where no systematic meta-analysis exists for a topic, systematic reviews without meta-analysis are included for that topic. Reviews were identified by searching the databases MEDLINE, EMBASE, and PsycINFO. Hand searching reference lists of identified reviews was also conducted. When multiple copies of reviews were found assessing the same topic, only the most recent and/or comprehensive review was included.

Review reporting assessment was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses ([PRISMA](#)) checklist that describes a preferred way to present a meta-analysis. Reviews with less than 50% of items checked have been excluded from the library. The PRISMA flow diagram is a suggested way of providing information about studies included and excluded with reasons for exclusion. Where no flow diagram has been presented by individual reviews, but identified studies have been described in the text, reviews have been checked for this item. Note that early reviews may have been guided by less stringent reporting checklists than the PRISMA, and that

some reviews may have been limited by journal guidelines.

Evidence was graded using the Grading of Recommendations Assessment, Development and Evaluation ([GRADE](#)) Working Group approach where high quality evidence such as that gained from randomised controlled trials (RCTs) may be downgraded to moderate to low if review and study quality is limited, if there is inconsistency in results, indirect comparisons, imprecise or sparse data and high probability of reporting bias. It may also be downgraded if risks associated with the intervention or other matter under review are high. Conversely, low quality evidence such as that gained from observational studies may be upgraded if effect sizes are large, there is a dose dependent response or if results are reasonably consistent, precise and direct with low associated risks (see end of table for an explanation of these terms)<sup>1</sup>. The resulting table represents an objective summary of the available evidence, although the conclusions are solely the opinion of staff of NeuRA (Neuroscience Research Australia).

### Results

We found one systematic review that met our inclusion criteria<sup>2</sup>.

- Moderate quality evidence suggests no differences in maternal education between people with bipolar disorder and people without bipolar disorder.

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### Common or distinct pathways to psychosis? A systematic review of evidence from prospective studies for developmental risk factors and antecedents of the schizophrenia spectrum disorders and affective psychoses

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| <b>Comparison</b>  | Parental education in people with bipolar disorder compared to people without bipolar disorder.  |
| <b>Summary of evidence</b>   | Moderate quality evidence (large samples, direct, imprecise, appears consistent) suggests no differences in maternal education between people with bipolar disorder and people without bipolar disorder. |
| <b>Parental education</b>  |  |
| <p><i>There were no significant differences between groups;</i></p> <p>1 study, N = 1,301,522</p> <p>Lower maternal education (&lt;2 years post-compulsory): OR = 1.01, 95%CI 0.72 to 1.42, <math>p &gt; 0.05</math></p> <p>Higher maternal education (&gt;4 years post-compulsory): OR = 1.07, 95%CI 0.80 to 1.42, <math>p &gt; 0.05</math></p> <p>1 study, N = 733</p> <p>Maternal - less than high school: OR = 1.27, 95%CI 0.72 to 2.25, <math>p &gt; 0.05</math></p> <p>Maternal - high school: OR = 0.87, 95%CI 0.54 to 1.41, <math>p &gt; 0.05</math></p> <p>Maternal - college (some or graduate): OR = 0.98, 95%CI 0.61 to 1.58, <math>p &gt; 0.05</math></p> |  |
| <b>Consistency in results</b>  | Appears consistent.  |
| <b>Precision in results</b>  | Imprecise  |
| <b>Directness of results</b>   | Direct   |

## Explanation of acronyms

CI = confidence interval, N = number of participants, OR = odds ratio,  $p$  = statistical probability of obtaining that result ( $p < 0.05$  generally regarded as significant)

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### Explanation of technical terms

\* Bias has the potential to affect reviews of both RCT and observational studies. Forms of bias include; reporting bias – selective reporting of results, publication bias - trials that are not formally published tend to show less effect than published trials, further if there are statistically significant differences between groups in a trial, these trial results tend to get published before those of trials without significant differences; language bias – only including English language reports; funding bias - source of funding for the primary research with selective reporting of results within primary studies; outcome variable selection bias; database bias - including reports from some databases and not others; citation bias - preferential citation of authors. Trials can also be subject to bias when evaluators are not blind to treatment condition and selection bias of participants if trial samples are small<sup>3</sup>.

† Different effect measures are reported by different reviews.

Prevalence refers to how many existing cases there are at a particular point in time. Incidence refers to how many new cases there are per population in a specified time period. Incidence is usually reported as the number of new cases per 100,000 people per year. Alternatively some studies present the number of new cases that have accumulated over several years against a person-years denominator. This denominator is the sum of individual units of time that the persons in the population are at risk of becoming a case. It takes into account the size of the underlying population sample and its age structure over the duration of observation.

Reliability and validity refers to how accurate the instrument is. Sensitivity is the proportion

of actual positives that are correctly identified (100% sensitivity = correct identification of all actual positives) and specificity is the proportion of negatives that are correctly identified (100% specificity = not identifying anyone as positive if they are truly not).

Weighted mean difference scores refer to mean differences between treatment and comparison groups after treatment (or occasionally pre to post treatment) and in a randomized trial there is an assumption that both groups are comparable on this measure prior to treatment. Standardized mean differences are divided by the pooled standard deviation (or the standard deviation of one group when groups are homogenous) which allows results from different scales to be combined and compared. Each study's mean difference is then given a weighting depending on the size of the sample and the variability in the data. 0.2 represents a small effect, 0.5 a medium effect, and 0.8 and over represents a large treatment effect<sup>3</sup>.

Odds ratio or relative risk ratio refers to the probability of a reduction ( $< 1$ ) or an increase ( $> 1$ ) in a particular outcome in the treatment group relative to the comparison group. For example, a RR of 0.75 translates to a reduction in risk of an outcome of 25% relative to those not receiving the treatment. Conversely, an RR of 1.25 translates to an increased risk of 25% relative to those not receiving treatment or not having been exposed to a certain risk factor. An RR of 1.00 means there is no difference between groups. The RR effect is statistically significant if the CI completely sits on either side of 1.00 and the  $p$  value is  $< 0.05$ . A medium effect is considered if  $RR > 2$  or  $< 0.5$  and a large effect if  $RR > 5$  or  $< 0.2^4$ . In OR stands for logarithmic OR where a  $\ln OR = 0$  shows no difference between groups and the  $\ln OR$  is statistically significant if the CI completely sits on either side of zero.

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Correlation coefficients (eg  $r$ ) indicate the strength of association or relationship between variables. They are an indication of prediction, but do not confirm causality due to possible and often unforeseen confounding variables. An  $r$  of 0.10 represents a weak association, 0.25 a medium association and 0.40 and over represents a strong association. Unstandardised ( $b$ ) regression coefficients indicate the average change in the dependent variable associated with a 1 unit change in the independent variable, statistically controlling for the other independent variables. Standardised regression coefficients represent the change being in units of standard deviations to allow comparison across different scales.

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‡ Inconsistency refers to differing estimates of treatment effect across studies (i.e. heterogeneity or variability in results) that is not explained by subgroup analyses and therefore reduces confidence in the effect estimate.  $I^2$  is the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance) - 0% to 40%: heterogeneity might not be important, 30% to 60%: may represent moderate heterogeneity, 50% to 90%: may represent substantial heterogeneity and 75% to 100%: considerable heterogeneity.  $I^2$  can be calculated from  $Q$  (chi-square) for the test of heterogeneity.

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§ Imprecision refers to wide confidence intervals indicating a lack of confidence in the effect estimate. Based on GRADE recommendations, a result for continuous data (standardised mean differences, not weighted mean differences) is considered imprecise if the upper or lower confidence limit crosses an effect size of 0.5 in either direction, and for binary and correlation data,

an effect size of 0.25. GRADE also recommends downgrading the evidence when sample size is smaller than 300 (for binary data) and 400 (for continuous data), although for some topics, this criteria should be relaxed<sup>5</sup>.

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|| Indirectness of comparison occurs when a comparison of intervention A versus B is not available but A was compared with C and B was compared with C that allows indirect comparisons of the magnitude of effect of A versus B. Indirectness of population, comparator and or outcome can also occur when the available evidence regarding a particular population, intervention, comparator, or outcome is not available so is inferred from available evidence. These inferred treatment effect sizes are of lower quality than those gained from head-to-head comparisons of A and B.

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### References

1. GRADEWorkingGroup. Grading quality of evidence and strength of recommendations. *British Medical Journal*. 2004; **328**: 1490.
2. Laurens K, Luo L, Matheson S, Carr V, Raudino A, Harris F, et al. Common or distinct pathways to psychosis? A systematic review of evidence from prospective studies for developmental risk factors and antecedents of the schizophrenia spectrum disorders and affective psychoses. *BMC Psychiatry*. 2015; **15**(1): 205.
3. CochraneCollaboration. Cochrane Handbook for Systematic Reviews of Interventions. 2008: Accessed 24/06/2011.
4. Rosenthal JA. Qualitative Descriptors of Strength of Association and Effect Size. *Journal of Social Service Research*. 1996; **21**(4): 37-59.
5. GRADEpro. [Computer program]. Jan Brozek, Andrew Oxman, Holger Schünemann. *Version 32 for Windows*. 2008.