Direct and indirect associations between dysfunctional attitudes, self-stigma, hopefulness and social inclusion in young people experiencing psychosis

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Abstract
Objective: Social inclusion and vocational activity are central to personal recovery for young people with psychosis. Studies with people experiencing long term psychosis suggest negative self-beliefs are important, but less is known about whether this association is present for young service users or about the potential influence of positive self-beliefs such as hopefulness. The aim of the current paper was to investigate the direct and indirect associations between dysfunctional attitudes, self-stigma, hopefulness, social inclusion and vocational activity for young people with psychosis.

Method: A 5-month longitudinal study was conducted with young psychosis service users. Measures of dysfunctional attitudes and self-stigma and vocational activity were obtained at baseline. Measures of hopefulness, social inclusion and vocational activity were obtained at follow-up.

Results: Hopefulness mediates the associations between self-stigma, social inclusion and vocational activity. Self-stigma may have a greater influence on social inclusion with age. Dysfunctional attitudes do not significantly predict social inclusion or change in vocational activity status.

Conclusion: Findings suggest that the impact of self-stigma may extend beyond social and occupational withdrawal and undermine subjective community belonging. Findings encourage an increased emphasis on facilitating hopefulness for young people who experience psychosis.

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1. Introduction

Psychosis commonly first occurs in adolescence or early adulthood and can disrupt the negotiation of developmental social and occupational tasks (Dudley et al., 2014; Erikson, 1968; Iarocci et al., 2008; Roy et al., 2013). Smaller social networks, reduced employment, education and voluntary occupations, and more passive compared to active leisure pursuits (Hodgekins et al., 2015; Shimitras et al., 2003; Macdonald et al., 2000; Revier et al., 2015) have been observed in psychosis. Thus young people with psychosis may lack social inclusion (Connell et al., 2015); the engagement in normative social and occupational activities coupled with subjective belonging and mattering (Lam et al., 2011; Eisenstadt et al., 2012; Priebe, 2007). Social inclusion is considered part of the process of personal recovery, helping to facilitate psychological adaptation (Brennanan and Lobo, 2011). Both objective and subjective indices matter, for increased objective activity not coupled with subjective belonging can reduce wellbeing (Corrigan and Buican, 1995; Hall, 2009). Social inclusion is not synonymous with full-time paid employment for this is not necessarily possible or desired by everyone experiencing psychosis (Priebe, 2007), and broader occupational, social and leisure activities also indicate recovery (Fowler et al., 2009). Mainstream vocational activity may however facilitate belonging (Rinaldi et al., 2010) and thus remains an important outcome.

Neurocognition, social cognition and psychosis symptoms influence social and occupational outcomes, but also leave significant variance unexplained (Couture et al., 2006; Green et al., 2000; Holshausen et al., 2014; Nuechterlein et al., 2011; Rinaldi et al., 2010). Thus clarity is needed as to additional explanatory variables. Beliefs about the self may be an important factor. Cognitive models suggest that neurocognitive problems give rise to dysfunctional attitudes, i.e. over-concern with failure and rejection (Beck et al., 1983; Beck et al., 2009). These attitudes provoke amotivation and anhedonia (negative symptoms), in turn leading to social and vocational disengagement (Grant and Beck, 2008; Beck et al., 2009; Horan et al., 2010). Similarly, self-stigma, the internalisation of negative societal stereotypes, leads to social and occupational withdrawal through provoking an emotional-behavioural ‘why try’ effect (Corrigan et al., 2009; Yanos et al., 2010). Like dysfunctional attitudes, self-stigma is linked to neurocognition and early symptoms (Beck et

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al., 2009; Livingston and Boyd, 2010), thus may be present at psychosis onset.

Empirical studies support the impact of dysfunctional attitudes and self-stigma on functioning in older schizophrenia populations (Brohan et al., 2010; Grant and Beck, 2008; Horan et al., 2010). Research with younger people is limited, yet age may moderate the impact of such beliefs. As negative self-beliefs are more normative in adolescence and cognitive maturity is reduced (D’Alessandro and Burton, 2006; Lewinsohn et al., 2001; Meiser and Esser, 2017), it can be hypothesised that the impact of these beliefs is reduced amongst younger people. However, equally an unclear self-concept could make self-stigma more impactful in youth (Yang et al., 2010).

Conversely hopefulness, self-agency and perceived pathways to meet goals (Snyder et al., 2002), is thought to facilitate social inclusion and personal recovery in psychosis (Berry and Greenwood, 2015; Hicks et al., 2012; Perry et al., 2007). Hopefulness within specific life domains, e.g. work and social, may be particularly relevant to social inclusion and malleable to intervention (Snyder et al., 2002). Hopefulness may also be a key mechanism by which negative self-beliefs affect outcome; the ‘why try’ effect of self-stigma can be conceptualised as reduced hopefulness, i.e. diminished belief in one’s abilities and opportunities to achieve life goals (Corrigan et al., 2009). However, there has been limited attention to the combined impact of negative and positive self-beliefs in clinical psychology research (Wood and Tarrier, 2010). Further exploration of the roles of both negative and positive self-beliefs in predicting social inclusion and vocational activity has clear relevance to the foci of youth psychosis interventions.

1.1. Hypotheses

It was hypothesised that first, dysfunctional attitudes and self-stigma would be negatively associated with social inclusion and vocational activity, secondly, the association with dysfunctional attitudes would be mediated by negative symptoms, thirdly, hopefulness would mediate the association between self-stigma, social inclusion and vocational activity, and finally, age would moderate associations between self-beliefs and social inclusion.

2. Methods

A convenience sample was assessed at two time-points. Negative self-beliefs, vocational activity, neurocognition and symptoms were measured at baseline. Hopefulness, social inclusion and a second assessment of vocational activity were measured 5 months later.

2.1. Participants and procedure

Young outpatient service users (18–36 years) with first episode psychosis (FEP), or a diagnosis of schizophrenia, schizoaffective disorder, puerperal psychosis, or bipolar disorder with psychosis, were recruited from Early Intervention in Psychosis, Community Mental Health and Assertive Outreach services (Table 1). Exclusion criteria were lack of capacity for informed consent or primary diagnosis of drug or alcohol dependence or drug-induced psychosis. Professionals first approached their clients and asked for consent to be contacted by the researcher, and if given, referred the participant to the study. Confirmed FEP, or diagnosis where relevant, was obtained from the treating psychiatrist or as documented in medical notes. Capacity was assessed by the first author prior to taking written consent. Additional methodological details relating to a linked study have been reported previously (Berry and Greenwood, 2015). Participants provided written informed consent before participating in face-to-face assessments in NHS or community locations. Ethical approval was obtained from the Brighton East NHS Research Ethics Committee (10/H1107/58). Assessments were conducted by the first author in 1–3 sessions within 1 week at each time-point.

2.2. Measures

2.2.1. Dysfunctional attitudes

The 25 Dysfunctional Attitudes Scale (DAS; Weissman and Beck, 1978) items are scored from 1 (totally agree) to 7 (totally disagree). Two subscales are derived, defeatist performance beliefs (e.g. “If I fail at my work, then I am a failure as a person”) and need for approval (e.g. “I cannot be happy unless most people I know admire me”); with confirmed reliability in psychosis (Horan et al., 2010). Means for defeatist performance (15 items; \( \alpha = 0.90 \)) and need for approval (10 items; \( \alpha = 0.85 \)) subscales were used presently; with higher scores reflecting greater negative self-beliefs.

2.2.2. Self-stigma

Self-stigma was measured using the Internalized Stigma of Mental Illness Scale (ISMI; Ritsher et al., 2003) which has 29 items rated from 1 (strongly disagree) to 4 (strongly agree), for example, “People discriminate against me because I have a mental illness”. The ISMI achieved high internal consistency (\( \alpha = 0.90 \)) with people experiencing serious mental health problems including psychosis (Ritsher et al., 2003). A mean score across the alienation, stereotype endorsement, discrimination experience, and social withdrawal subscales was used (\( \alpha = 0.92 \)), as the fifth subscale, stigma resistance, represents not self-stigma but rather a reaction to it (Lysaker et al., 2008). Higher scores represent greater self-stigma.

2.2.3. Hopefulness

Hope across academic, work, social, family, romantic, and leisure life domains was captured using the Domain-Specific Hope Scale (DSHS; Symson, 1999). Respondents rated eight items in each life area, for example, “I can always get a date if I set my mind to it” (romantic hope), from 1 (definitely false) to 8 (definitely true). Excellent internal reliability (\( \alpha = 0.93 \)) was achieved with young people previously (Symson, 1999). Currently a mean for all 48 items was used (\( \alpha = 0.97 \)), with higher scores reflecting greater hopefulness.

2.2.4. Social inclusion

Based on a new social inclusion measurement model in young people (Berry and Greenwood, 2017), social inclusion comprised mean composite scores for two domains; social activity (\( \alpha = 0.72 \)) and community belonging (\( \alpha = 0.71 \)). Social activity comprised indicators of social network size and reciprocity and social contact. Social network size and reciprocity were measured using the Social Relationship Scale (SRS; McFarlane et al., 1981) capturing number of relationships and their reciprocity across work, home and family, money, personal health, personal and social, and society. Social contact was measured using three items from the Social Inclusion Scale (SIS; Secker et al., 2009), for example “I have friends I see or talk to every week”, rated from 1 (not at all) to 4 (yes definitely) for the last month. Community belonging comprised items from the SIS representing cultural inclusion (e.g. “I have been to new places”; 3 items), political inclusion (“I have felt clear about my rights”; 2 items), and subjective belonging (“I feel that what I do is valued by others”; 3 items).

2.2.5. Vocational activity

Following Norman et al. (2007), employment (paid and voluntary) and education were included in ‘vocational activity’. Vocational activity was measured as a self-reported status (yes or no), with ‘yes’ indicating regular vocational activity in the month preceding the assessment.

2.2.6. Covariates

2.2.6.1. Clinical symptoms. The observer-rated Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987) was used to measure positive (7-items), negative (7-items), and general (16-items) symptoms, from 1 (none) to 7 (most severe). The total PANSS score (range 30–210) was
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