



Validation of the Integrative Hope Scale in people with psychosis

Beate Schrank^{a,b,*}, Andreas Woppmann^c, Astrid Grant Hay^b, Ingrid Sibitz^a,
Sonja Zehetmayer^d, Christoph Lauber^e

^a King's College London, Institute of Psychiatry, Denmark Hill, London SE5 8AF, United Kingdom

^b Medical University Vienna, Department of Psychiatry and Psychotherapy, Währinger Gürtel 18–20, 1090 Vienna, Austria

^c University of Vienna, Department of Sociology, Rooseveltplatz 2, 1090 Vienna, Austria

^d Medical University of Vienna, Section of Medical Statistics, Spitalgasse 23, 1090 Vienna, Austria

^e University of Liverpool, Department of Psychiatry, 2nd Floor Block B, Waterhouse Building, 1–5 Brownlow Street, Liverpool L69 3GL, United Kingdom

ARTICLE INFO

Article history:

Received 23 July 2011

Received in revised form 22 November 2011

Accepted 31 December 2011

Keywords:

Hope

Measurement

Schizophrenia

Confirmatory factor analysis

Validation

ABSTRACT

Hope is an important variable in mental health, particularly in the emergent field of research focused on recovery and well-being. This study validates the “Integrative Hope Scale” (IHS) for use in people with severe mental illness. Two hundred participants diagnosed with schizophrenia or schizoaffective disorder were assessed using the IHS, the Centre for Epidemiological Studies Depression Scale, and the Positive and Negative Syndrome Scale. Sixty participants were re-assessed after 14 days to establish re-test reliability. Confirmatory factor analysis was carried out; correlations between the scales and kappa coefficients were used to establish validity and reliability. The factor analysis confirmed a four-factor solution with excellent model fit, after minor modifications to the initial model. Discriminant validity and internal consistency were excellent. Test–retest reliability was good except for one item. This study suggests the scale to be a valid, reliable and feasible tool for the assessment of hope in people with severe mental illness. It provides a sound basis for future research on hope in mental health. For use in people with psychosis, we suggest some minor modifications to the scale.

© 2012 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Hope has been a relevant factor in mythology, philosophy and religion for centuries. Its introduction into the field of medicine, however, occurred only in the 1950s when Karl Menninger identified it as integral to the profession of psychiatry, important for initiating therapeutic change, willingness to learn and personal well-being (Menninger, 1959). Today, the psychiatric literature offers a number of reasons why hope is a relevant variable in mental health practice and research: Hope is central to the concept of recovery from mental disorders, both as a trigger of the recovery process and as a maintaining factor (Bonney and Stickley, 2008; Whitley and Drake, 2010). In line with the increased emphasis on recovery, person-centred integrative care was established as a policy goal in numerous countries all over the world (Mezzich and Salloum, 2007) with hope being a central factor in all of its aspects (Cloninger, 2011). In this context, personal well-being is increasingly viewed as a primary outcome of therapeutic strategies, and hope is considered an important factor associated with well-being (Slade, 2009). Hope is also essential for the concept of resilience (Ong et al., 2006), for human adaptation, and for psychotherapeutic change (Magaletta and

Oliver, 1999; Hayes et al., 2007), being consistently identified as a key factor in psychotherapy by patients, family members and therapists in various settings (Schrank et al., 2008; Redlich et al., 2010).

In people with severe mental disorders, specifically psychosis or schizophrenia, hope was shown to have a consistent negative association with depression, overall psychopathology, as well as with family problems and barriers to employment. Most frequent and consistently positive associations were found with perceived recovery, self-efficacy, self-esteem, empowerment, spirituality, quality of life, and social support (Schrank et al., 2012). This clearly points to the important role of hope for recovery and resilience. For a number of variables, however, correlations have not been replicated or inconclusive study results pose important further questions as to the specific mechanisms by which hope acts in the recovery process. This includes, for example, a negative association between hope and the awareness dimension of insight (Hasson-Ohayon et al., 2009), while qualitative studies clearly suggest insight into illness and treatment as a factor supporting hope because it gives people the tools to manage their symptoms (Kirkpatrick et al., 2001).

Another reason for these inconsistent results on hope in mental health, and especially in people with psychosis, may be the large number of overlapping but not equivalent hope concepts and their various corresponding scales that can be found in the literature (Schrank et al., 2008). The most frequently used scales in psychiatric research include the four specific hope scales by Snyder, Herth, Miller and Zimmerman (Snyder State Hope Scale, Snyder et al., 1996; Herth Hope Index, Herth, 1992; Miller Hope Scale, Miller and Powers, 1988; Zimmerman Hope Scale,

* Corresponding author at: Health Services and Population Research Department, King's College London, Institute of Psychiatry, PO Box 29, Denmark Hill, SE5 8AF London, United Kingdom. Tel.: +44 20 7848 5782, +43 650 2141 618(Mobile); fax: +44 20 7277 1462.

E-mail addresses: beate.schrank@gmail.com, beate.schrank@kcl.ac.uk (B. Schrank).

Zimmerman 1990, as well as the sub-scale on hope on the Recovery Assessment Scale (Schrank et al., 2012). These tools show a considerable overlap but still differ in important areas, making the comparison of research results difficult. For example, the Herth Hope Index is the only one to extensively and explicitly cover spiritual aspects of hope, while the Zimmerman scale draws heavily on negative aspects of hopelessness, and the Snyder scale narrowly focuses on goals and perceived agency and pathways to achieve goals. Miller's scale is the most comprehensive one but unfeasible in research with people with psychosis due to its high number of items. None of the scales was validated for people with severe mental illness. The sub-scale on hope on the Recovery Assessment Scale shows a narrow coverage of hope domains similar to Snyder's scale but, being embedded in a recovery context, at the same time blurs the distinction between the concepts of hope and recovery themselves which are especially important to answer differentiated questions in recovery-oriented research (Schrank et al., 2012).

To help bridge the important research gap posed by the lack of a comprehensive, valid, reliable and feasible hope scale, we conducted a comprehensive literature review incorporating all hitherto published definitions of hope and identified a number of key dimensions integral to the concept (Schrank et al., 2008). On the basis of this comprehensive definition, and drawing on the most frequently used hope scales in psychiatric research, we developed an integrative hope scale that spans all relevant dimensions. The 23-item "Integrative Hope Scale" (IHS) is available in the English and German languages. It yields one overall score, and the exploratory factor analysis showed four stable factors: "trust and confidence", "positive future orientation", "social relations and personal value" and "lack of perspective". Apart from covering all relevant dimensions of hope found in the literature, the IHS is more concise when compared with pre-existing assessment instruments. It is easy to use and shows excellent psychometric properties in the general population. None of the other existing measurement tools for hope meets all these criteria (Schrank et al., 2011).

The aim of the present study was to validate the IHS for use in people with severe mental illness in order to provide a sound basis for future research on hope in the emergent field of mental health research focused on recovery and well-being.

2. Methods

2.1. Subjects

Participants were recruited from the psychiatric university clinic and all four existing psychiatric wards at community hospitals as well as from two low threshold community mental health services in Vienna. Patients were included on the condition they were above 18 years of age, had a diagnosis of schizophrenia or schizoaffective disorder according to ICD-10 criteria (Dilling et al., 2009), had sufficient knowledge of the German language and were capable of giving written informed consent. Memory impairment that would preclude participating in the research interviews, co-morbidity with known serious physical illness and a primary diagnosis of substance abuse disorder were exclusion criteria for the study.

2.2. Materials

The following instruments were used for data collection

- (i) The *Integrative Hope Scale (IHS)* contains 23 items that are rated on a 6-point Likert scale and comprehensively cover the complex concept of hope. The German version shows good psychometric properties in the general population with Cronbach's alpha for the overall scale at 0.92 and between 0.80 and 0.85 for its four dimensions as well as highly satisfactory results for its concurrent and discriminant validity (Schrank et al., 2011).
- (ii) The "*Allgemeine Depressionsskala*" (ADS) is the German version of the widely used CES-D (Center for Epidemiological Studies Depression Scale) (Radloff, 1977). Its 20 items assess depressive symptoms as rated on a 4-point Likert scale with higher scores indicating higher depression. Validity and reliability have been found to be highly satisfactory (Hautzinger and Bailer, 1993).
- (iii) The *Positive and Negative Syndrome Scale (PANSS)* is the most widely used measure of symptom severity in psychosis. The 30-item scale is administered by a trained rater who evaluates patients' current severity level on each symptom by endorsing one of seven options. The PANSS has demonstrated high internal reliability and good construct validity (Kay et al., 1987) and is an established

reliable instrument for the assessment of psychopathology in psychosis patients in its German version (Müller et al., 2000).

- (iv) The *Client Socio-Demographic and Service Receipt Inventory (CSSRI-EU)* is an interviewer-administered questionnaire suitable for use with psychosis patients (Chisholm et al., 2000). It was developed as a standard measure for the assessment of service utilisation in the European Union. The German version was adapted to the specifications of service provision structures in German-speaking countries and has proved effective in its practical application (Roick et al., 2001). In the presented study only the sections relevant to assess socio-demographic background information including the social network were applied.

2.3. Procedures

The study was approved by the ethics committee of the Medical University Vienna as part of a larger prospective study protocol. One research worker checked the inclusion criteria for all current inpatients at the participating hospitals and for the scheduled outpatients at the community mental health services on a weekly basis. Criteria were confirmed by the responsible psychiatrist and eligible patients were approached by the research assistant. Participants gave their written informed consent before inclusion in the study. The trained and constantly supervised research worker first administered the CSSRI-EU and the PANSS; the patients filled out the self-assessment questionnaires (IHS and ADS) thereafter. Sixty participants were randomly chosen to receive the IHS again after an average of 14 days (range 12–16) to establish its test-retest reliability.

2.4. Statistical analysis

A confirmatory factor analysis (CFA) was performed for the IHS. CFA is superior to exploratory factor analysis since it allows postulating a theoretical model and tests its validity based on the sample data (Byrne, 2009). If the computed goodness-of-fit is acceptable, the described model argues for the plausibility of assumed relations among all observed variables. For the initial model we postulated the factor structure found in the general population which includes four different factors with 23 variables overall.

Normality was assessed by observing skewness, kurtosis, histograms and Q-Q plots. To achieve a stable factor matrix, we excluded all cases with at least one missing response. For the CFA a Maximum Likelihood estimator was used.

Internal consistency for the IHS overall and for the individual factors was established using Cronbach's alpha, calculated from the pairwise correlations between items, and reported along with the corresponding 95% confidence interval derived by bootstrapping. Test-retest reliability for the IHS overall and for the individual factors was calculated with weighted kappa coefficients and the corresponding 95% confidence intervals.

ADS, IHS and PANSS and their respective factors were calculated by the mean of the respective items. PANSS scores were established to adequately describe the psychopathology of the sample in which the IHS was validated and to allow comparison with future research on hope in people with psychosis. To assess the discriminant validity of the IHS, the correlation of the overall scale and its individual factors was calculated with the ADS overall score. Similarly, to assess correlations between positive and negative symptoms and hope, the IHS overall score was correlated with the PANSS overall and sub-scores. Spearman's rho was used for all these correlations.

Global significance level for all statistical test procedures conducted was chosen at $\alpha = 0.05$. All statistical analyses were conducted with the software package SPSS 15 and AMOS 7.

3. Results

3.1. Population

Two hundred patients participated in the assessments. Twenty-four of these had at least one missing response in the IHS and were hence excluded from the confirmatory factor analysis. For all other calculations, only those participants with five or more missing items on any one scale were excluded. This applied to the IHS in five cases and to the ADS in two cases. Six participants specifically refused to take part in the PANSS assessment but filled out the remaining questionnaires. The characteristics of all 200 participants are displayed in Table 1.

Fifty-three (26.5%) of the participants had a current diagnosis of schizoaffective disorder and 147 (73.5%) of another schizophrenia spectrum disorder (including mainly ICD-10 F20, but also F22 and F23). Many patients, however, reported changes in diagnoses during their illness history, including a switch between these two. The participants' mean age was 42 years (S.D. 12.6; range 19 to 77), their self-reported mean age at first illness onset was 24 (S.D. 7.5; range 3 to 48) and the mean duration of illness 17.4 years (S.D. 12.9; range 0.7 to 54.4).

The mean PANSS overall score was 45.72 (S.D. = 10.0), PANSS positive 11.69 (S.D. = 4.3), PANSS negative 11.17 (S.D. = 3.6) and PANSS

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات