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Development of a self-report measure of social functioning for forensic inpatients

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ABSTRACT

Despite increasing interest in the measurement of social functioning in people with personality disorder, there are currently no social functioning measures specifically for forensic or other inpatients with a diagnosis of personality disorder. This paper describes the development and validation of the Hospital Social Functioning Questionnaire (HSFQ), a self-report measure of social functioning for forensic inpatients. A sample of fifty four male inpatients in a forensic personality disorder treatment unit completed the HSFQ and a range of measures indicative of social functioning, namely self-report measures of psychological wellbeing and symptoms, recorded incidents of self-harm and aggression. Clinicians' ratings of global functioning, and clinically assessed personality disorder severity were also collected. The HSFQ showed good internal consistency and test–retest reliability, good concurrent validity with self-report measures of personality pathology, other symptoms and psychological wellbeing, but only a moderate correlation with clinician-rated global functioning and with frequency of self-harm and aggressive behavior. These results suggest that the HSFQ is a more focused measure of social functioning than the Global Assessment of Functioning (GAF), which conflates social functioning with self harm and aggressive behavior. The HSFQ is a potentially useful assessment of social functioning in secure and other inpatient settings.

1. Introduction

The revision of the DSM and ICD diagnostic criteria for personality disorder has drawn attention to the assessment of personality disorder severity. The DSM-5 alternative model for personality disorders (American Psychiatric Association, 2013) argues that disturbances in self and interpersonal functioning form the core of personality disorder. Self functioning is defined as the stability and accuracy of the sense of self and the ability to pursue coherent and meaningful goals, while interpersonal functioning is defined as the ability to empathize, and to form and maintain close, mutual interpersonal relationships. In the new DSM-5 classification system, each of these aspects of self and interpersonal functioning is rated for severity on a five-point scale. Tyrer et al. (2011) have proposed an alternative severity scale for ICD-11. They argue that persistent and pervasive interpersonal and social dysfunction is both a defining feature and the core of personality disorder and their severity scale assesses this dysfunction. Although Tyrer et al. acknowledge the importance of a dysfunctional sense of self in personality disorder, they consider its measurement to be too complex to be clinically useful. Leaving aside this difference, the two systems are broadly similar, and in both cases social functioning is central to the assessment of personality disorder severity.

Tyrer (1993) defined social functioning as 'the level at which an individual functions in his or her social context' (p. 8), which includes domains of reciprocal interactions with others, leisure activities, employment or education, and intimate relationships. Rutter (1987) argued that personality disorder is underpinned by "a persistent, pervasive abnormality in social relationships" (p. 454), while Livesley (1998) defined personality disorder as the failure of three separate but interrelated systems: the ability to form stable and integrated representations of self and others, the ability to establish intimacy and function as an attachment figure, and the ability to behave in a cooperative and prosocial manner in social groups.

Clearly, valid and reliable measures of social functioning are required for the assessment of this aspect of personality disorder. Social functioning measures can be divided into self-report and clinician-rated measures. Clinician-rated measures have the advantages of being less susceptible to social desirability responding (Weissman, 1975), and may be more reliable with individuals for whom impaired social functioning is related to poor insight (Crowe, Beauchamp, Catroppa, & Anderson, 2011). However, they have been criticized for being open to clinician bias about what constitutes 'normal functioning' (Tyrer et al., 2005; Weissman & Bothwell, 1976). Self-report measures may be less reliable with individuals who are lacking in insight or responding in a socially desirable manner, but have the advantages of being simple to administer, and they allow respondents to rate not only their performance in social and occupational activities, but also how satisfying or distressing they find these activities (Paykel, Weissman, Prusoff, & Tonks, 1971; Remington & Tyrer, 1979). This is arguably of particular interest with people with personality disorder, where distress in social or occupational functioning is a defining

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feature of the disorder (American Psychiatric Association, 2013). Therefore, the focus of this paper is on developing a self-report measure.

There are a number of existing self-report measures of social functioning. Some, like the Sheehan Disability Scale (SDS; Sheehan, Harnett-Sheehan & Raj, 1996) and the Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear & Greist, 2002) consist of Likert scales on which respondents rate their performance in different roles. The SDS consists of three items, rating the extent to which respondents' symptoms have disrupted their work, social life and family life, while the WSAS consists of five items rating the extent of impairment in respondents' performance in work, home management, social leisure activities, private leisure activities and their ability to form and maintain close relationships with others. Other self-report measures measure stress and satisfaction as well as performance. For example, the Outcome Questionnaire—45 (OQ-45; Lambert et al., 1996) measures symptomatic distress, interpersonal relationships (intimate, family and social) and social role performance (employment, family roles and leisure). The interpersonal and social role performance items relate to role stress and satisfaction as well as performance. The Social Functioning Questionnaire (SFQ; Tyrer et al. 2005) measures performance in work and home tasks, relationships with family, sexual activities, social contacts and spare time activities, as well as financial concerns, stress in completing tasks and enjoyment of leisure activities. Finally, the Social Adjustment Scale—Self-Report (SAS-SR: Weissman, 1999) measures functioning in the domains of work, social and leisure activities, relationships with extended family, role as a marital partner, parental role and role within the family. For each domain, questions probe performance, interpersonal friction and satisfaction.

All these self-report measures of social functioning assess functioning across a number of domains that reflect the demands of independent living in the community. However, there is a mismatch between the domains assessed by these measures and the lived experiences of psychiatric inpatients, and particularly forensic inpatients, whose opportunities to engage in activities such as employment, family interactions, and intimate relationships are both limited and highly controlled. Moreover, most interpersonal interactions for these patients will be with mental health professionals or other patients, neither of whom match any of the categories referred to in existing measures. There is therefore a need to develop a robust self-report measure of social functioning that reflects the experiences and demands encountered by forensic inpatients.

Here, we describe the development of the Hospital Social Functioning Questionnaire (HSFQ) in consultation with patients in a high secure hospital who were diagnosed with personality disorder. Based on the premise that good social functioning is associated with good psychological health and wellbeing (Casey, Tyrer & Platt, 1985; Weissman, Myers & Harding, 1978), the concurrent validity of the new HSFQ was examined by correlating HSFQ scores with other measures indicative of social functioning, namely self-report measures of psychological wellbeing and symptoms, recorded incidents of self-harm and aggression, clinicians' ratings of functioning, and clinically-assessed personality disorder severity. It was hypothesized that participants' scores on the new measure would show a positive correlation with clinicians' assessment of functioning, and negative correlations with measures of psychological distress, personality pathology, and self-harm and aggressive behaviors. Internal consistency and test–retest reliability were also examined. The performance of the HSFQ was compared with the Global Assessment of Functioning (GAF; American Psychiatric Association, 1994), the other main social functioning assessment not tied to community settings.

2. Method

2.1. Design

The study was cross-sectional in design. A sample size calculation was carried out using STPLAN software version 4.5. Assuming a significance level of 0.05, a power of 0.80 and a small to medium level of correlation between variables (0.40), a sample size of forty six was indicated to obtain reliable correlations.

2.2. Participants

Participants were male patients with a primary diagnosis of personality disorder in a high secure psychiatric hospital in the United Kingdom. Participants were excluded if they lacked the mental capacity to give informed consent to participate in the study or were unable to comprehend research procedures. From a total of 105 male patients with a primary diagnosis of personality disorder, fifty four (51.43%) agreed to participate. All were detained under mental health legislation and had been assessed as meeting the criteria for one or more personality disorders using the International Personality Disorder Examination, DSM-IV-TR version (IPDE; Loranger, 1999).

2.3. Measures

2.3.1. Patient information

Information on participants' age, date of admission, axis I diagnoses, and personality pathology was collected from files. Personality disorder is routinely assessed on admission to the service using the IPDE, a structured clinical interview. Thereafter, personality disorder pathology is assessed regularly using the self-report Personality Assessment Inventory (PAI; Morey, 2007). Here, IPDE information is used to describe the sample, but data from the two PAI scales measuring personality pathology, the antisocial and borderline scales, were used in the analysis to reflect more recent personality pathology.

2.3.2. Hospital Social Functioning Questionnaire (HSFQ)

The HSFQ was developed with a focus group of seven patients from a pre-discharge ward in the service where the research took place. The focus group was presented with a list of domains used in existing measures of social functioning in community settings and asked to select and adapt these for relevance to life in hospital. The group agreed on a list of ten domains (looking after living environment, self-care, finance, work, recreation, family relationships, social relationships with staff, social relationships with patients, working relationships with staff, and managing stress). They then generated descriptors of good social functioning in each of these domains and agreed on the most important descriptors. The group agreed on the previous month as being an appropriate timeframe for the questionnaire. The lead author then generated 19 items based on these descriptors. Twelve items were positively worded and seven items were negatively worded. The order of items was randomized and a four-point scale added (0 = most of the time, 1 = quite often, 2 = sometimes, 3 = not at all). The questionnaire was reviewed by the focus group, who agreed that the wording was clear, the time frame was appropriate and the response options were clear. The HSFQ is presented in Appendix A. To score the HSFQ items 1, 3, 4, 5, 6, 7, 8, 9, 11, 15, 16, and 19 are reverse-scored and the item scores are added together. Higher scores correspond to better functioning.

2.3.3. General Health Questionnaire (GHQ-12; Goldberg, 1992)

The GHQ-12 is a 12-item self-report measure of psychological wellbeing that is widely used in non-forensic community-based clinical practice, epidemiological studies, and research (Hankins, 2008). Items were scored using the Likert method and a single composite score used for analyses. Higher scores correspond to poorer psychological wellbeing.

2.3.4. Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983)

The HADS is a 14-item self-report measure of caseness and severity of anxiety and depression. It has been widely used and validated in