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Differences in coping, self-efficacy, and external control beliefs between patients at-risk for psychosis and patients with first-episode psychosis



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ABSTRACT

Patients with first-episode psychosis (FEP) often show dysfunctional coping patterns, low self-efficacy, and external control beliefs that are considered to be risk factors for the development of psychosis. Therefore, these factors should already be present in patients at-risk for psychosis (AR). We compared frequencies of deficits in coping strategies (Stress-Coping-Questionnaires, SVF-120/SVF-KJ), self-efficacy, and control beliefs (Competence and Control Beliefs Questionnaire, FKK) between AR ($n=21$) and FEP ($n=22$) patients using a cross-sectional design. Correlations among coping, self-efficacy, and control beliefs were assessed in both groups. The majority of AR and FEP patients demonstrated deficits in coping skills, self-efficacy, and control beliefs. However, AR patients more frequently reported a lack of positive coping strategies, low self-efficacy, and a fatalistic externalizing bias. In contrast, FEP patients were characterized by being overly self-confident. These findings suggest that dysfunctional coping, self-efficacy, and control beliefs are already evident in AR patients, though different from those in FEP patients. The pattern of deficits in AR patients closely resembles that of depressive patients, which may reflect high levels of depressiveness in AR patients. Apart from being worthwhile treatment targets, these coping and belief patterns are promising candidates for predicting outcome in AR patients, including the conversion to psychosis.

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1. Introduction

Poor coping skills are associated with dysfunctional competence beliefs in terms of low self-efficacy and predominantly external control beliefs in healthy individuals (Jex et al., 2001; Thiruchelvi and Supriya, 2012). Poor coping skills and low self-efficacy have also been reported by patients with chronic schizophrenia (Berry et al., 2006; Diez-Alegría et al., 2006). Moreover, schizophrenia patients frequently demonstrated dysfunctional control beliefs by overly attributing causes for negative events to external factors instead of internal factors (Kanay and Bentall, 1989). Studies further examining the extent to which excessive external control beliefs implicated other persons (external-personal) or situational factors (external-situational) revealed that the externalizing bias of schizophrenia patients manifests itself in blaming others, and not situational

factors, for negative events (Diez-Alegría et al., 2006). Such an excessive use of external-personal control beliefs is called “personalizing bias” (Kinderman and Bentall, 1997). This bias is frequently present in patients with acute paranoid symptoms but not in patients in remission (Diez-Alegría et al., 2006; Aakre et al., 2009).

Dysfunctional coping strategies and competence/control beliefs have been linked to symptom severity (Strous et al., 2005; Janssen et al., 2006) and poor clinical outcome in schizophrenia (Martins and Rudnick, 2007; Harrow et al., 2009). In addition, these deficits were also evident in patients with first-episode psychosis (FEP) (Horan et al., 2007; Fornells-Ambrojo and Garety, 2009; Pruessner et al., 2011). In vulnerability-stress-coping models (Nuechterlein and Dawson, 1984), deficient coping and competence/control beliefs are regarded as enduring vulnerability factors for the development of psychosis. Consequently, these features should be present in help-seeking patients symptomatically at-risk for psychosis (AR), and may contribute to improve the prediction of conversion to psychosis. A recent meta-analysis (Fusar-Poli et al., 2012) reported mean conversion rates of 18% after 6 months of

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follow-up, 22% after 1 year, and 29% after 2 years. Regarding remission rates, another meta-analysis found that 73% of AR patients did not convert to psychosis during a 2-year follow-up, and 46% of these non-converters achieved full clinical remission (Simon et al., 2013).

Comparing group means, AR patients reported, on average, less pronounced positive coping strategies and more pronounced negative coping strategies than healthy controls and even FEP patients (Lee et al., 2011; Pruessner et al., 2011; Jalbrzikowski et al., 2012; Phillips et al., 2012). One study (Pruessner et al., 2011) found that FEP and AR patients did not differ significantly in a global measure of self-esteem, including self-competencies. However, both groups scored significantly lower than healthy controls. No study has compared competence beliefs in terms of self-efficacy between these groups yet. With respect to control beliefs, only two studies have investigated them in AR patients thus far (DeVylder et al., 2012; Thompson et al., 2012). These studies reported inconsistent results: one study found that AR patients had significantly more external control beliefs than healthy controls (Thompson et al., 2012) while the other study revealed no difference between both groups (DeVylder et al., 2012). Both studies did not involve FEP patients as a comparison group and did not differentiate between personal and situational externalizing biases. We hypothesized that both groups differ from each other in coping and competence/control belief patterns. Moreover, we assumed that coping patterns are associated with competence/control beliefs in both groups.

Studies so far have only compared group means. Consequently, these results might have suffered from a regression to the mean as deficient coping and competence/control beliefs involve responses both below and above the normal (mid)range. Therefore, we compared frequencies of deficits according to the provided test norms in coping strategies and competence/control beliefs between AR and FEP patients and not mean performances. The application of this statistical approach seems to be especially appropriate to bring new insights in the nature of these understudied constructs in AR and FEP patients. However, due to the small sample size our results need to be interpreted with caution and require replication in future studies.

2. Methods

2.1. Participants and procedure

In this cross-sectional-study, data were collected in a sample of 21 AR patients seeking help for mental health problems at the Bern Early Recognition and Intervention Centre for mental crisis (FETZ Bern) between December 2010 and March 2012, and in a sample of 22 FEP in- and outpatients. Both AR and FEP patients were consecutive referrals. The refusal rate was 9% in the AR and 15% in the FEP group. The AR group had to meet the ultra-high risk criteria according to the Structured Interview for Psychosis-Risk Syndromes (SIPS) (McGlashan et al., 2010) and/or the basic symptom criteria according to the Schizophrenia Proneness Instrument, Adult (SPI-A) (Schultze-Lutter et al., 2007) or Child version (SPI-CY) (Schultze-Lutter and Koch, 2010; Fux et al., 2013). The FEP group was assessed after clinical stabilization as defined by the absence of frank psychotic positive symptoms, i.e. delusion, hallucination or disorganized communication, according to the psychiatrist in charge. The clinical diagnoses of psychosis and other axis I disorders were assessed using the Mini International Neuropsychiatric Interview (MINI/KID) (Sheehan et al., 1998). Patients were excluded if they had a medical, neurological, or substance use disorder accounting for the mental problems. Patients with substance-induced psychotic disorders were included in the sample but they did not fulfill the criteria for substance dependence. Any past or present psychotic disorder was an additional exclusion criterion for the AR group. All diagnostic assessments were performed by trained psychologists and supervised by Frauke Schultze-Lutter to assure the highest quality of assessments. The ethical committee of the University of Bern approved the study. All participants provided written informed consent and parental consent if they were under the age of 18.

2.2. Assessments

2.2.1. Stress-Coping-Questionnaire (SVF)

The German Stress-Coping-Questionnaires for adults (SVF-120) (Janke et al., 1997) and for children/adolescents (SVF-KJ) (Hampel et al., 2001) were used to assess coping strategies. SVF-120 and SVF-KJ define coping strategies as a person's habitual reactions to stressful situations. Each item is rated on a 5-point Likert scale. Response categories range from "not at all" to "in any case" depending on how frequently a person uses a given coping strategy. Both adult and youth versions allow for the calculation of a summary score of "positive coping strategies" and "negative coping strategies" from 16 (SVF-120) and 9 (SVF-KJ) primary scales, respectively. In both versions, "minimization", "distraction", "situation control", "positive self-instructions", and "social support" are regarded as positive coping strategies. "Passive avoidance", "rumination", "resignation", and "aggression" are summarized as negative coping strategies. Normative data are provided in the form of *T*-values.

2.2.2. Competence and Control Beliefs Questionnaire (FKK)

The German Competence and Control Beliefs Questionnaire (FKK) (Krampen, 1991) was applied to evaluate beliefs on own competencies and expected courses of action in terms of self-efficacy ("self-concept") and control beliefs on both positive and negative events. Control beliefs are defined as causal attributions of events to oneself ("internality"), to other persons ("social externality"), or to chance/situational factors ("fatalistic externality"). This corresponds to the distinction made in the Internal, Personal and Situational Attributions Questionnaire (IPSAQ) (Kinderman and Bentall, 1996) between internal (equals "internality"), personal-external (equals "social externality"), and situational-external (equals "fatalistic externality") control beliefs. In the FKK, each of these four primary scales ("self-concept", "internality", "social externality", "fatalistic externality") consists of eight items that are rated on a scale from "1" ("totally false") to "6" ("totally true"). Normative data are provided in the form of *T*-values.

2.3. Data analyses

Raw scores of SVF and FKK were converted into standard *T*-values (mean: 50 ± 10) according to the test norms. In line with the interpretation of test norms provided by the respective test manuals, the 'normal range' was defined by *T*-values between 40 and 60, 'deficits' by values outside this range. The SVF provides both age- and gender-adjusted norms derived from the general population (Janke et al., 1997; Hampel et al., 2001); the FKK norms are only age-adjusted because gender had no effect on competence and control beliefs (Krampen, 1991). Therefore, the influence of age and gender effects (Table 1) has already been accounted for by the use of test norms. Consequently, age and gender were not included as moderator variables in the analyses.

The resulting *T*-scores of both questionnaires, SVF and FKK, were classified into three categories: below the normal range ($T < 40$) (category 1), within the normal range ($T = 50 \pm 10$) (category 2), or above the normal range ($T > 60$) (category 3). The 'exact option' for two-tailed χ^2 -tests was used to test if AR and FEP differ in the frequency of these three categories. If group differences were present, two post-hoc tests were performed using Fisher's exact test in order to locate pairwise group differences: post-hoc test 1 compares the frequency of any deficit (category 1 plus category 3) versus the frequency of scores within the normal range (category 2) between AR and FEP; and post-hoc test 2 compares the frequency of both types of deficits, i.e. below-norm deficit (category 1) versus above-norm deficit (category 3) between AR and FEP. This procedure has the advantage that we needed only two post-hoc tests instead of performing all three possible pairwise group comparisons.

Correlations between coping ("positive coping strategies" and "negative coping strategies") and competence/control beliefs ("self-concept", "internality", "social externality", "fatalistic externality") were examined with Kendall's tau.

Due to the small sample size, we did not expect to reveal significant clinically meaningful group effects. Therefore, the effect sizes Cramer's *V* for group comparisons and Kendall's tau for correlations were chosen as the main statistical descriptors, and no correction for multiple testing was performed. For both effect sizes, almost moderate values of at least 0.25 were regarded as indicators of relevant group differences (Schultze-Lutter et al., 2012).

3. Results

3.1. Sample characteristics

The sample consisted of 43 patients, 21 AR patients and 22 FEP patients, between 11 and 34 years of age. Detailed sample characteristics are reported in Table 1. All patients received treatment. AR patients received psychotherapy in an individual and/or group setting and three persons also received medication management (one patient: antidepressant, one person:

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