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How do differential explanations of voice-hearing influence attributions and behavioral intentions towards voice-hearers?

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ABSTRACT

Explanations regarding the etiology of mental health difficulties have been found to affect public attitudes towards those who experience such difficulties. Utilizing a large, randomized parallel-groups design ($N=1004$), we examined how standardized differential explanations of voice-hearing influence public attitudes, attributions, and behavioral intentions towards voice-hearers. Additionally, we incorporated a behavioral outcome measure to examine whether reported behavioral intentions towards voice-hearers were related to responses towards an individual with a history of voice-hearing. Consistent with attribution theory, mediated pathways between attributions and intentions were identified: broadly, viewing the voice-hearer's behavior as dangerous, within their personal responsibility, and global was associated with more coercive intentions – and these were mediated by feelings of fear, anger, and pity. Reported behavioral intentions demonstrated small-to-moderate associations with our behavioral outcome measure. The findings suggest that explanations regarding the etiology of mental health difficulties that seek to reduce public attributions of dangerousness, personal responsibility, and globality may facilitate more helpful responses towards voice-hearers.

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1. Introduction

Epidemiological studies suggest that voice-hearing is a relatively common experience in the general population, with prevalence rates reported to be around 10% (Beavan et al., 2011; Johns et al., 2002; Tien, 1991). Despite this, within Western societies, voice-hearing is popularly *perceived* (however inaccurately) to be aberrant and extraordinary (Beavan and Read, 2010; Leudar and Thomas, 2000) and associated with mental illness (Moskowitz et al., 2011) – most commonly, schizophrenia (American Psychiatric Association [APA], 2013; Jorm and Griffiths, 2008) – irrespective of whether the experience of voice-hearing causes distress or impairment of functioning.

Contemporary medical explanations broadly emphasize the role of biological and/or genetic factors (e.g., disease of the brain; changes in brain structure; heritability) in the etiology of schizophrenia and voice-hearing experiences more generally (ecological factors are increasingly attended to within these explanations, but biological/genetic factors tend to receive greater emphasis). However, biological and genetic factors alone are insufficient to

explain the idiographic complexity of voice-hearing phenomena. Individual voice-hearing experiences and voice-content do not appear random, and are often personally and culturally meaningful (e.g., Anthony, 2004): suggesting that consideration of psychological development and social environment is important to understanding and working with voice-hearing experiences (National Institute for Health and Care Excellence [NICE], 2010).

Explanations that emphasize the role of psychosocial factors in the etiology and maintenance of voice-hearing underpin a number of contemporary evidence-based approaches to working with distress or impairment that may arise in relation to voice-hearing experiences (National Institute for Health and Care Excellence [NICE], 2010)¹. Contemporary evidence-based approaches commonly invoke the stress-vulnerability model (Zubin and Spring, 1977) as a potential biopsychosocial explanation for the onset of voice-hearing (Garety, 2003): suggesting that voice-hearing experiences emerge from an interaction between stressful circumstances/contexts (including familial) and underlying vulnerability

¹ We acknowledge that there is a multiplicity of psychological and sociological explanations of voice-hearing, some of which are associated with particular therapeutic approaches and supportive interventions (Hayward et al., 2014). We focus here on two explanatory frameworks underpinning current evidence-based approaches: stress-vulnerability and cognitive models.

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or propensity factors (which may include biological or organismic features).

Cognitive explanations of voice-hearing have highlighted ways in which appraisal biases may lead people to 'hear' thoughts as independent voices (Bentall, 1990) or misattribute their inner-speech (Morrison and Haddock, 1997). These explanations also implicate potential source-monitoring difficulties (e.g., Morrison et al., 2003; Waters et al., 2012) wherein the individual attributes internal experiences to external phenomena. Broadly, these cognitive accounts emphasize that voice-hearing has continuities with wider cognitive experience: they offer a normalizing explanation of etiology and place greater emphasis on *adaptation* to the experience of voice-hearing. In terms of cognitive approaches to adaptation, the model of Chadwick and Birchwood (1994) has been prominent (Thomas et al., 2014). This model suggests that the emotional and behavioral consequences of voice-hearing are influenced by the voice-hearer's beliefs about the voices (their identity, intention, and power) and perceived self-efficacy – which may relate to broader beliefs about the self and others (Birchwood et al., 2004).

Further to the (biological and psychosocial) explanations that underpin contemporary evidence-based approaches to understanding and working with voice-hearing, such experiences are conceptualized as a spiritual or religious phenomenon in some cultures and communities. For example, in South Africa, Xhosa people who hear voices are supported to become indigenous healers (Sodi, 1995, cited in Thomas and Leudar, 1996). Although spiritual/religious accounts of voice-hearing are diverse, from this perspective, the origin and maintenance of voice-hearing can be broadly understood as selective direction and communication from a higher being or spiritual entity – or as an individual having special receptivity to such messages (McCarthy-Jones et al., 2013). Spiritual understandings represent just one 'alternative' to the biological and psychosocial models that dominate professional discourse and practice in Western cultures: Voice-hearers draw on a diverse range of explanations for their voice-hearing experiences, and this diversity is explicitly respected and validated by the international Hearing Voices Movement, which explicitly encourages individuals to develop their own explanatory framework as 'experts by experience' (Corstens et al., 2014).

The explanations used to make sense of voice-hearing experiences may have important implications for how: (a) the general public understands and responds to voice-hearers, (b) mental health professionals work with voice-hearers, and (c) voice-hearers make sense of their voice-hearing experiences (Lebowitz and Ahn, 2014). In particular, the way we explain voice-hearing may impact on the social stigma experienced by those who hear voices – i.e., how the broader community relates and responds to voice-hearers. Individuals perceived to have mental health difficulties are often marginalized, socially excluded, and considered dangerous by others, particularly when their voice-hearing is interpreted as a symptom of schizophrenia (Angermeyer and Dietrich, 2006). It would seem that mental health professionals are also susceptible to holding stigmatizing attitudes towards those with mental health difficulties (e.g., Magliano et al., 2004; Schulze and Angermeyer, 2003) with research indicating that these attitudes can influence the use of coercive treatments and segregation (Rao et al., 2009).

Claims have been made that medical conceptualizations should reduce stigma towards 'mental illness' by highlighting that 'illnesses' are outside the control and responsibility of the individual (Angermeyer et al., 2011). However, research examining the influence of differential explanations regarding the etiology and maintenance of 'mental illness' on public attitudes towards those deemed to be 'mentally ill' has produced mixed results. For example, some authors (e.g., Angermeyer et al., 2004; Lincoln et al.,

2008; Read, 2007) report that biological/medical explanations of mental illness increase stigma by eliciting attributions of dangerousness, in turn leading to fearful emotional responses and social-exclusionary intentions (Corrigan, 2000; Corrigan and Shapiro, 2010). Similarly, Dietrich et al. (2004) found that people report a greater desire for social distance when understanding schizophrenia to be caused by biological factors. However, in a recent meta-analysis, Kvaale et al. (2013) found that biological explanations of 'mental illness' did not affect reported social distancing, but did induce pessimistic attitudes and elevate perceptions of dangerousness.

Given the negative consequences of stigmatization, it is important to consider how public attitudes towards voice-hearers might operate and be influenced. Attribution theory provides a useful framework for understanding this process (e.g., Weiner, 1979, 1980, 1985, 1995; Weiner et al., 1976). Within attribution theory, attitudes are understood to incorporate three linearly-related components: cognitions (attributions), emotions, and behavioral intentions (e.g., Reber and Reber, 1995). An attribution is a cognitive process through which individuals make sense of events, behaviors, and the world around them. These attributions are posited to influence emotional responses, which in turn mediate behavioral intentions (e.g., Corrigan, 2000). For example, if we observe a person falling over, the way that we attribute the behavior will impact upon our feelings and intentions towards that person: if the behavior is attributed to be uncontrollable (e.g., physical disability), related to an internal locus of causality (e.g., biological condition), outside of the individual's personal responsibility (e.g., hereditary), and stable over time (e.g., long-term condition), we may feel sympathy and wish to help that person (e.g., Corrigan, 2000; Weiner, 1995). In contrast, if we view that person's behavior as controllable, within their personal responsibility, and unstable (e.g., they are acutely intoxicated) we may experience wariness and keep our distance (e.g., Corrigan, 2000; Weiner, 1995). In addition to the attributions outlined above (controllability, personal responsibility, locus of causality, and stability) attributions of globality (versus specificity) – i.e., whether behaviors or events are seen to be situationally-specific or constant across all situations (Abramson et al., 1978) – are also considered to be influential determinants of attitudes.

Further to these commonly-recognized attributions, a recent systematic literature review concluded that people frequently make attributions that individuals with a 'mental illness' are dangerous (Jorm et al., 2012), leading to reported avoidance of such individuals, and a preference for coercive treatments and segregation (Corrigan et al., 2003; Link et al., 1999). Fig. 1 provides an overview of the attribution model, incorporating core attributions and components discussed above.

The way people respond to individuals who have experiences

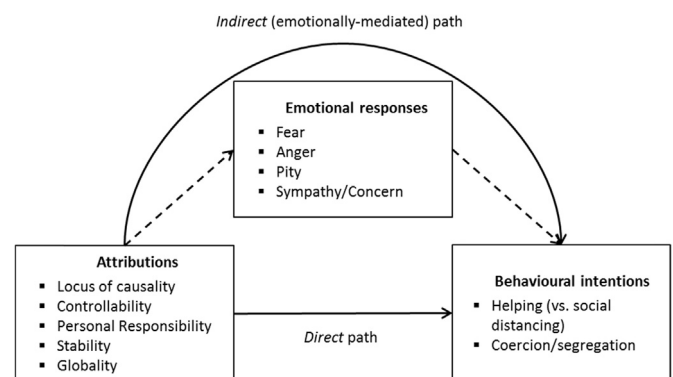


Fig. 1. Overview of the attribution model (based on pathways outlined by Corrigan, 2000).

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