



Metacognitive mastery in persons with first-episode psychosis and their caregivers: Implications for timely help-seeking and caregiver experiences.

Brief report



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A B S T R A C T

While metacognitive mastery seems to be closely linked to general functioning in persons with psychosis, little is known of metacognitive capacity of family members, who often play an important role in recovery and often report high levels of distress. We gathered assessments of metacognitive mastery from persons with first-episode psychosis and their mothers. We found that relatively higher overall mean mastery levels among the dyads, was related to less negative caregiver experiences, and less caregiver criticism. Greater levels of mastery were related to decreased duration of untreated psychosis. Clinical implications in terms of family intervention programmes repertoire are discussed.

1. Introduction

Metacognition refers to the range of mental activities that allow people to both recognize specific thoughts and feelings and to integrate perceptions of intentions, thoughts, feelings, and connections between events into larger complex representations (Lysaker et al., 2015; Semerari et al., 2003). Metacognition deficits have been observed in persons in early and later phases of schizophrenia-spectrum disorders and linked to poorer outcomes (Trauelsens et al., 2016). One form of metacognitive capacity, metacognitive mastery, or the ability to use metacognitive knowledge to respond to psychosocial challenges (Carcione et al., 2011), has been closely linked to outcomes, including passive coping, social anxiety (Lysaker et al., 2011), social withdrawal (Lysaker et al., 2010) and general inactivity (Snethen et al., 2014).

One limitation of this literature is that it has considered the metacognitive capacities of patients independent of the metacognitive capacity of family members who often play a major role in any movements towards well-being, especially early in the course of illness. Only one study has examined metacognition in caregivers, finding that caregivers of persons with first episode psychosis (FEP) with greater levels of metacognition reported higher levels of positive caregiver

experiences (Jansen et al., 2014). Understanding the role of mastery in FEP seems especially important given needs to intervene early and prevent prolonged dysfunction.

To explore this issue, the current study gathered assessments of metacognitive mastery from persons with FEP and mothers in cases where the two were living together. Given the increased emotional, physical, and fiscal challenges of being a parent of a child with FEP living at home (Lowyck et al., 2004; Sin et al., 2007), especially during the early course of psychosis, we focused on biological maternal caregivers living with their child. Further, mothers were of specific interest given that they often report increased distress (Tennakoon et al., 2000) and are generally the primary caregiver (Cotton et al., 2013; Jansen et al., 2015a; Onwumere et al., 2011; Scazufca and Kuipers, 1997) of a person experiencing psychosis. We then examined whether the level of metacognitive mastery in patients and/or their caregivers was related to the quality of the caregiving relationship and how long the patient initially waited after the onset of illness to seek treatment. Mastery was chosen because if it is difficult for a caregiver to identify and synthesize their own mental states and the mental states of others, including their child, it could be difficult to cope with challenges and distress associated with caregiving. Further, with limited under-

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standing of one's mental states, it could be difficult to not only identify psychological challenges their child is facing, but also to respond to their child and their needs in an adaptive way.

1.1. Hypotheses and exploratory questions

Our primary hypothesis was that greater metacognitive mastery among FEP patients and maternal caregivers would predict decreased duration of untreated psychosis, greater positive and less negative caregiver experiences, and decreased caregiver critical comments and emotional overinvolvement. In addition, we reasoned that both overall mean level of mastery as well as the overall differences in levels of mastery of the dyad were uniquely related to outcomes. Here we formed two complementary hypotheses; first that higher overall levels of mastery would predict better outcomes and second, that at a more nuanced level, more concordant levels of mastery would predict better outcomes. Regarding the later hypotheses, we reasoned that more discordant levels of mastery could result in greater levels of misunderstanding, resulting in poorer caregiver relationships.

2. Methods

2.1. Participants

Participants included 19 men and 9 women with FEP (ICD-10 F20-29, except F21) and their maternal caregiver drawn from a larger study examining caregiver distress and family interventions. Detailed information on sample selection has been presented elsewhere (Jansen et al., 2015b). Participants in the study sample did not differ from the larger sample on any study measures. Patients had a mean age of 20.01 (SD=3.03), and mild to moderate levels of positive and negative symptoms. Mothers had a mean age of 48.33 (SD=5.00).

2.2. Measures

Duration of untreated psychosis (DUP) was defined as Positive and Negative Syndrome Scale for Schizophrenia (PANSS; Kay et al., 1987), psychotic symptom score of ≥ 4 either constantly for a week or several times a week for several weeks (Melle et al., 2006). Metacognitive mastery in patients and caregivers were assessed by the Indiana Psychiatric Illness Interview (IPII; Lysaker et al., 2002) and the Metacognition Assessment Scale – abbreviated (MAS-A; Lysaker et al., 2005; Semerari et al., 2003). Experience of caregiving was assessed with the 66-item Experience of Caregiving Inventory (ECI; Szumukler et al., 1996). Expressed emotion was assessed with the 20-item Family Questionnaire (Wiedemann et al., 2002). Negative and positive symptoms were assessed with the PANSS, using a factor structure from Bell et al. (1994). Description and psychometric properties of the measures, including the Danish MAS-A, are described elsewhere (Jansen et al., 2015b, 2014; Trauelsen et al., 2016).

2.3. Procedure

Patients and their caregivers were approached for participation when they entered treatment. Following informed written consent, questionnaires and semi-structured interviews were administered. The Regional Committee for Research Ethics approved the study (reg.nr. 2008580020).

2.4. Analyses

First, the average and absolute difference mastery score for each mother and patient dyad was calculated. Given that metacognitive mastery and negative symptoms were significantly correlated in the larger patient sample used in this study (Trauelsen et al., 2016) as well as in previous studies (Lysaker et al., 2005), we used negative

Table 1

Means and standard deviations for study measures ($n = 28$).

Variables	M	SD	Observed range	Possible range
Patient				
MAS-A – Mastery: Patient	4.39	1.40	1 – 7	0 – 9
DUP in weeks ^c	109.54	171.43	2 – 832	
PANSS – Negative symptoms	15.75	5.56	8 – 27	8 – 56
Caregiver				
PANSS – Positive symptoms	12.54	5.32	6 – 22	6 – 42
MAS-A – Mastery: Mother	6.13	1.87	2 – 8.5	0 – 9
ECI – Positive caregiver experiences	29.04	9.12	7 – 46	0 – 56
ECI – Negative caregiver experiences	75.32	29.27	12 – 129	0 – 208
FQ – Caregiver critical comments	18.36	4.71	10 – 30	10 – 40
FQ – Caregiver emotional overinvolvement	24.32	5.22	16 – 36	10 – 40
Combined				
MAS-A – Average dyad Mastery ^a	5.26	1.38	1.75 – 7	0 – 9
MAS-A – Absolute difference dyad Mastery ^b	2.09	1.36	0 – 5	0 – 9

Note: MAS-A = Metacognition Assessment Scale Abbreviated; DUP = Duration of untreated psychosis; ECI = Experience of Caregiving Inventory; FQ = Family Questionnaire; PANSS = Positive and Negative Syndrome Scale.

^a Average of mother and patient mastery;

^b Absolute difference between mother and patient mastery;

^c Four missing.

symptoms as a covariate in the remaining analyses. To test our primary hypothesis, we conducted partial correlations between both maternal and patient mastery scores and DUP duration of untreated psychosis, positive and negative caregiver experiences, and caregiver critical comments and emotional overinvolvement, controlling for negative symptoms. In examining the distribution of scores one participant's DUP score appeared as an outlier. To ensure results were not unduly affected, we winsorized this outlier, and found that the partial correlation results were not significantly different. Additional hypotheses were tested by calculating partial correlations between both the average dyad mastery score and the absolute difference dyad mastery score and the abovementioned measures controlling for negative symptoms. Based on directional a priori hypotheses, all correlations were one-tailed.

3. Results

Descriptive statistics for study measures are in Table 1. Mean patient mastery scores suggest at best an ability to seek support when facing psychosocial challenges, while mothers were able to alter behavior and cognitions when facing psychosocial challenges. Controlling for negative symptoms, maternal mastery was significantly associated with patient mastery ($r = .36$, $p = .03$). Additional partial correlations are in Table 2. After controlling for patient symptoms, increased patient mastery was significantly associated with decreased negative caregiver experiences ($p = .002$) and caregiver critical comments ($p = .009$). Increased maternal mastery was significantly associated with decreased duration of untreated psychosis ($p = .02$) and caregiver critical comments ($p = .048$) after controlling for negative symptoms. Increased average dyad mastery scores were significantly associated with decreased duration of untreated psychosis ($p = .047$), negative caregiver experiences ($p = .01$), and caregiver critical comments ($p = .009$) independent of negative symptoms. Finally, increased absolute differences in dyad mastery scores were significantly associated with greater caregiver emotional overinvolvement ($p = .02$) after controlling for negative symptoms.

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