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Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Self esteem and self agency in first episode psychosis: Ethnic variation and relationship with clinical presentation



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ARTICLE INFO

Article history:

Received 16 July 2014

Received in revised form

28 February 2015

Accepted 3 March 2015

Available online 31 March 2015

Keywords:

First episode psychosis

Self esteem

Locus of Control

Clinical presentation

Ethnicity

ABSTRACT

The impact of self esteem and Locus of Control (LoC) on clinical presentation across different ethnic groups of patients at their first psychotic episode (FEP) remains unknown. We explored these constructs in 257 FEP patients (Black $n=95$; White British $n=119$) and 341 controls (Black $n=70$; White British $n=226$), and examined their relationship with symptom dimensions and pathways to care. FEP patients presented lower self-esteem and a more external LoC than controls. Lower self esteem was associated with a specific symptoms profile (more manic and less negative symptoms), and with factors predictive of poorer outcome (longer duration of untreated psychosis (DUP) and compulsory mode of admission). A more external LoC was associated with more negative symptoms and an insidious onset. When we explored these constructs across different ethnic groups, we found that Black patients had significantly higher self esteem than White British. This was again associated with specific symptom profiles. While British patients with lower self esteem were more likely to report delusions, hallucinations and negative symptoms, Black patients with a lower self esteem showed less disorganization symptoms. These findings suggest that self esteem and LoC may represent one way in which social experiences and contexts differentially influence vulnerable individuals along the pathway to psychosis.

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1. Introduction

Although self perceived individual value (self esteem) and the sense of being in control of one's own behaviors (Locus of Control, LoC) are considered critical psychological constructs in modeling symptom severity and illness course in psychosis (Garety et al., 2001), very few studies have explored both concepts in the same clinical population, before engagement with services and the illness itself have become established. Furthermore, no study has taken into account ethnic differences when evaluating how these

constructs shape care pathways and outcome. These factors need to be taken into account to advance our understanding of the clinical relevance of these concepts, particularly in terms of treatment strategy and outcome.

Feeling inferior and inadequate may be crucial to the origin of symptoms such as delusions or hallucinations (Bentall et al., 1994) and may influence the derogatory content and persistence of these symptoms (Bentall et al., 1994; Garety et al., 2001). Indeed, changes in self esteem over time have been associated with fluctuation in symptom severity (Rotter, 1966; Thewissen et al., 2008). Moreover, a disturbed self esteem has been implicated in maintaining florid paranoid ideation (Häfner et al., 2005). However, the relationship between specific symptom profiles and self esteem levels at the time of first engagement with mental health services has never been explored.

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The ability to recognize oneself as the agent of a behavior (LoC) reflects the extent to which individuals believe that they can control the events that affect them and ultimately establishes the ground from which they act and evaluate their own activities in everyday life (Jeannerod, 2003). An altered (external) LoC may therefore be relevant to the formation of positive symptoms (Waters and Badcock, 2010). For example, even when abnormal perceptual experiences are described in patients with schizophrenia and non-patient voice-hearers, a reduced sense of ownership and control over the auditory hallucinations is only present in the patient group (Honig et al., 1998).

Self esteem and LoC are also likely influence clinical presentation. For example, a low self esteem has been associated with poor pre-morbid adjustment (Romm et al., 2011), while a higher self esteem has been associated with better coping strategies in individuals with chronic severe mental health problems, and particularly in those with psychosis (Borras et al., 2009). Likewise, believing that the consequences of personal behaviors are strongly related to powerful others rather than oneself (“my family has a lot to do with my becoming sick or staying healthy”) (Levenson, 1973) may contribute to a passive attitude toward care and to the use of ineffective coping strategies, with consequent worse clinical and functional outcomes (Kunikata et al., 2005; Eklund and Backstrom, 2006).

To date, the only existing studies conducted in patients at the early stages of psychosis have evaluated either self esteem or LoC, with inconsistent findings. In these studies, a low self esteem has been associated with negative and depressive, but not with positive symptoms (Palmier-Claus et al., 2011), and with poor pre-morbid adjustment but not good quality of life (Pruessner et al., 2011; Romm et al., 2011). Interestingly, interventions that increase self esteem have shown beneficial effects on both social and cognitive function in patient with chronic schizophrenia as well as in first psychotic episode (FEP) participants (Gumley et al., 2006; Ostergaard Christensen et al., 2014). Only one of these studies (Pruessner et al., 2011) included a sample of healthy controls, and showed that they had a higher self esteem than a small sample of FEP. Only one study evaluated LoC in FE patients, finding that a more external LoC is associated with more severe positive symptoms and poor help-seeking behavior, but not with a longer duration of untreated psychosis (DUP) (Skeate et al., 2002).

Of note, self esteem and LoC have never been evaluated in relation to ethnicity in patients with psychosis. This is important as individuals from black minority ethnic groups in the general population show a higher self esteem than other ethnic groups (Bachman et al., 2011). Although different levels of self esteem may not explain the higher rate of psychosis previously reported among black ethnic groups, they may be helpful in understanding some of the clinical characteristic often reported in patients from these groups. For example, higher levels of self esteem may help to explain the lower self harm rates and the lower use of prescribed antidepressants reported in black minority patients (McKenzie et al., 1995; Morgan et al., 2005). Also, a greater sense of personal worth, and the accompanying higher self-assurance may help to explain the difficulties black minority patients have in seeking initial help, their higher rates of compulsory admissions, and their worse pathway to care (McKenzie et al., 1995; Morgan et al., 2005). Interestingly, ethnic differences in LoC have never been explored, either in the general population or in patients with psychosis.

This study investigated the impact of self esteem and the sense of being in control of one's own behaviors on early clinical presentation and pathways to care in a large epidemiological sample of individuals with a first episode of psychosis and in a population-based comparison group, with a particular focus on variations by ethnic group. Using a first episode sample limits the potential impact of a long-standing illness and service use on

these psychological factors, and the inclusion of a large general adult population provides important information on a reference group.

We hypothesized that: 1) compared to controls, patients with psychosis would show a lower self esteem and a more external LoC, and that this would be particularly the case for White British patients; 2) that in patients, a lower self esteem and a more external LoC would be associated with a less favorable mode and timing of presentation to psychiatric services (longer DUP, higher rate of compulsory admissions and insidious illness onset), irrespective of ethnicity.

2. Methods

2.1. Sample

This research forms part of the *ÆSOP* (Aetiology and Ethnicity in Schizophrenia and Other Psychosis) study, a multi-center epidemiological study of first-episode psychosis. All subjects aged 16–64 years resident in defined areas of south-east London and Nottingham who consecutively presented for the first time to the local psychiatric services for a functional psychotic illness (ICD-10, F10–19, F20–F29, F30–F33 psychotic coding) (WHO, 1992) over a 3-year period were included in the study. Exclusion criteria were: the presence of a disease of the central nervous system; moderate or severe learning disabilities as defined by ICD-10 (WHO, 1992); poor fluency in English language; and transient psychotic symptoms resulting from acute intoxication as defined by ICD-10 (WHO, 1992). A random population based sample of control subjects was selected using the same sampling frame as that used by the Office of Population and Census Statistics (OPCS) Psychiatric Morbidity Survey, namely the postal address file (PAF) (Jenkins and Meltzer, 1995). The PAF was used to generate a random sample of 10 target addresses for each case from which controls were recruited. Each address was contacted three times (morning, afternoon, and evening) to find an eligible control subject (age between 16 and 65 years) who was willing to participate. This method broadly matches cases and controls by area of residence in the two catchment areas of the study (South-East London and Nottingham). All potential controls completed the Psychosis Screening Questionnaire (Bebbington and Nayani, 1995) and were excluded if they met criteria for a present or past psychotic disorder as well as any of the criteria above (Dazzan et al., 2004, 2005; Morgan et al., 2006). We included in this study all patients and healthy controls who completed the LoC and self esteem measures. The local ethical committee granted ethical approval for the study, and the participants gave written informed consent, in accordance with the Declaration of Helsinki.

2.2. Clinical Assessment

Psychopathology was assessed using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (WHO, 1994) and ratings are based on clinical interview, case-note review and information from informants (e.g. health professionals). All SCAN interviews were conducted as soon as possible after first contact with psychiatric services. Diagnoses were made according to ICD-10 criteria (WHO, 1992) by consensus in meetings with senior clinicians where all clinical information was presented. Symptom ratings were calculated according to the SCAN's Item Group Checklist (IGC) algorithm, and the most prevalent ones (available for at least 10% of cases) were then clustered into five different groups: manic, reality distortion (presence of delusions and hallucinations), negative, depressive, and disorganization symptom dimensions (Demjaha et al., 2009).

All the available information (e.g. patients' medical notes) was used to establish characteristics of illness presentation and contact with psychiatric services, including: mode of onset, mode of contact (voluntary or compulsory), and duration of untreated psychosis (DUP, defined as the period from the first clear description of psychotic phenomena, from any source, to first contact with statutory mental health services).

The ethnicity of the participants was based on subject self-asciption; participants were asked to assign themselves to an ethnic group according to the categories devised for the 1991 UK census (Fearon et al., 2006). Black African and Black Caribbean are the largest ethnic minority groups in the areas in which the study was conducted. There were no significant differences between these two groups in the psychological constructs we investigated. For the purposes of this study, we therefore explored two ethnic groups based on self-asciption by ethnicity: 1) White British and, 2) Black (i.e., Black African and Black Caribbean).

2.3. Self esteem and Locus of Control

Self esteem, considered a unidimensional construct reflecting positive or negative attitudes toward the self (Rosenberg, 1965), was assessed with the Rosenberg Self Esteem Scale (Rosenberg, 1989). The scale is a 10-item self-report

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