



Life hassles, experiential avoidance and distressing delusional experiences

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ABSTRACT

Life hassles have been implicated in both the formation and maintenance of psychosis symptoms. However, little is understood about the mechanism through which these stressors impact on psychosis. The current study proposed experiential avoidance (EA), a psychological coping style that is a central focus for change in Acceptance and Commitment Therapy (ACT), as a potential mediator of the link between life hassles and both the emergence and maintenance of delusional ideation. Participants were recruited to a non-clinical sample ($N = 133$) and a clinical sample of psychosis patients ($N = 100$). All participants completed a self-report questionnaire including a measure of delusions and delusional distress (Peters Delusions Inventory), life hassles (Survey of Recent Life Experiences) and EA (Acceptance and Action Questionnaire-II). Mediation testing (bootstrapping) indicated a significant mediation effect of EA in the relationship between life hassles and both delusions and delusional distress, in both clinical and non-clinical samples. The findings suggest that individuals (irrespective of their diagnostic status) with a tendency to suppress or avoid unwanted thoughts are significantly more likely to experience distressing delusions in response to stressful life occurrences. The use of ACT and Cognitive Behavioural Therapy to reduce EA in those at risk of emerging delusions and in patients with an already established psychosis is discussed.

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Daily life hassles have been found to prospectively predict subjective distress and symptom exacerbations in psychosis patients, indicating that life events need not be of great magnitude to influence psychosis (Horan, Blanchard, Clark, & Green, 2008). Existing psychological literature has highlighted the negative impact of stressful life events on psychosis at three distinct stages; sub-acute symptoms in the vulnerability to psychosis in non-clinical populations (Lincoln, 2009; Nicholson & Neufeld, 1992), a worsening of prodromal symptomatology in at-risk populations (Ord, 2008) and maintenance of psychotic symptoms in clinical populations (Docherty, St-Hilaire, Aakre, & Seghers, 2009). Thus, there is evidence that stress is involved in both the proneness and maintenance of psychotic symptomatology.

As Myin-Germeyns and van Os (2007) noted however, too little is understood about the mechanism through which these stressors impact on psychosis. Indeed, whilst research has strongly supported a basic connection between the two, the mediating mechanisms translating stress into psychotic symptoms, and the specificity of the association, are not clearly established (Lincoln, 2009).

The current study proposes experiential avoidance (EA), a psychological coping strategy, as a potential mediator of the link between life stress and both the emergence and maintenance of psychosis symptoms. EA, otherwise referred to as psychological inflexibility, is a process involving excessive negative evaluations of unwanted private thoughts, feelings and sensations, along with an unwillingness to experience these events and deliberate efforts to control or escape from them (Hayes, Strosahl, & Wilson, 1999). The paradox of EA is that attempting to inhibit unpleasant thoughts may only increase their frequency and the distress associated with them (Gross, 2002). Indeed, thought suppression (a core component of EA) has been proposed as a disorder-complicating moderator of psychopathology with detrimental consequences for psychological functioning and wellbeing (Najmi & Wegner, 2008). EA is also thought to be harmful because it may impede an individual's capacity to effectively respond to challenging experiences or emotional stimuli (Hayes et al., 2004). EA may thus negatively impact on a person's ability to accept undesirable thoughts and feelings and pursue their goals in the presence of these potentially difficult private experiences (McCracken & Zhao-O'Brien, 2010). Consideration of EA as a generalized diathesis and toxic process will be useful in improving our understanding of the aetiology of mental disorder (Kashdan, Barrios, Forsyth, & Steger, 2006).

Whilst EA is a relatively new construct, one recent study concluded that EA was a significant predictor of paranoia amongst

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a student population (Udachina et al., 2009). In the same study, the only one thus far to posit a link between stress, EA and psychosis symptom formation, the researchers found that EA was particularly damaging when high levels of stress were also present (Udachina et al., 2009). Amongst already established psychoses, Acceptance and Commitment Therapy (ACT), a psychological intervention directed at reduction of EA, has been linked to decreased hospitalization, lower symptom believability and a reduction in associated distress in patients with schizophrenia (Bach & Hayes, 2002; Gaudiano & Herbert, 2006). Thus, limited existing research supports the notion that EA is linked to both the emergence and ongoing maintenance of psychosis symptoms in non-clinical and clinical populations respectively.

As a coping mechanism, EA has been found to be a core mechanism in the development and maintenance of psychological distress in general and a lower quality of life (Hayes et al., 2004). High EA has been associated with diminished frequency of positive life events and increased frequency of negative life events and negative affective experiences (Gross & John, 2003; Kashdan et al., 2006). EA is proposed to contribute to distress by leading to increased rumination on negative events and a consequent disruption of pleasant, engaging, and spontaneous activity (Kashdan et al., 2006). Concerning distress in psychosis specifically, Campbell and Morrison (2007) found that punishment and worry-based thought control strategies (analogous to EA) were found to be associated with increased distress and frequency of delusions. Indeed, EA appears to play a role in the exacerbation of symptoms and associated distress, however, as Kashdan and Rottenberg (2010) noted, there is a need for research to clarify the role of psychological inflexibility in the predisposition to psychopathology.

In this context, the current study sought to establish whether EA may mediate the relationship between life hassles and the vulnerability to delusional ideation and associated distress. Psychosis research has increasingly tended to focus on individual symptoms, rather than diagnoses, as psychotic symptoms seem to have specific correlates, suggesting differential risk factors for these symptoms (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001; Johns et al., 2004). Delusions, a core feature of clinical psychosis, have also been found to occur in milder forms in the wider community (Johns & van Os, 2001; Laroi & Van der Linden, 2005).

A non-clinical sample was recruited to investigate the relevance of EA in the emergence of delusional ideation in psychologically healthy individuals. Additionally, a clinical sample of psychosis patients was also assessed to explore the potential role of EA in the ongoing maintenance of delusions amongst those with an already established psychosis. It was hypothesized that life hassles would predict delusions in both non-clinical and clinical samples, with this relationship mediated by EA, such that those individuals who attempted to cope with life hassles in an experientially avoidant manner, would experience more frequent and distressing delusions.

Methods

Participants and procedures

The non-clinical sample consisted of 133 participants recruited via the La Trobe University School of Psychological Science Participant Registry and through advertising on internet social networking sites (Facebook). All participants completed the 179-item-questionnaire on line via a survey hosting website that included a participation and information consent form, which all participants read prior to commencing the survey.

100 Participants with a diagnosed psychotic disorder were also recruited to the study through two clinical and two disability support services in Melbourne, Australia. After being presented with a study description, mental health case managers from these services identified clients they deemed appropriate and informed them about how to meet up with the researcher, if they were interested. On all occasions, the first author, or the client's mental health case manager, was present with the participant to ensure informed consent and facilitate completion of the questionnaire. All participants completed the same survey as the non-clinical sample, only in paper format. The inclusion criterion for the study was a diagnosis of a psychotic disorder in a non-acute phase, as confirmed by the referring mental health worker. No formal diagnostic assessment was possible, however, self-reported diagnosis was measured in the questionnaire. Patients in an acute phase of care were excluded from the current study due to concerns of the reliability of self-reports and potential for distress whilst completing the questionnaire. Amongst the clinical sample, 82% reported a primary diagnosis of schizophrenia, whilst 18% indicated a diagnosis of schizoaffective disorder. Comorbid diagnoses noted by clinical participants included major depressive disorder (44%), substance abuse/dependency (39%) and anxiety disorders (37%).

Table 1 compares the demographic characteristics of the non-clinical and clinical samples.

Compared to the clinical sample, non-clinical participants were significantly younger ($\chi^2(3, 233) = 36.91, p < .01$), more likely to be female ($\chi^2(1, 233) = 5.43, p = .02$), more likely to be in full time employment or study ($\chi^2(3, 233) = 142.31, p < .01$) and had higher levels of education ($\chi^2(1, 233) = 75.33, p < .01$).

Measures

The 21-item Peters Delusions Inventory (PDI) (Peters, Day, McKenna, & Orbach, 1999) was used to measure the vulnerability to delusions (total score) and subscale score for delusional distress. Cronbach's α for the PDI in the current study was .80, consistent with the findings of the scales authors (.82) (Peters, Joseph, Day, & Garety, 2004).

The 51-item Survey of Recent Life Experiences (Kohn & Macdonald, 1992) was used to measure life hassles. The scale comprises 6 factors: Social and cultural difficulties, work, time pressure, finances, social acceptability and social victimization (Kohn & Macdonald, 1992). Responses were made on a 4-point

Table 1
Demographic information for both samples.

	Non-clinical sample (N = 133)	Clinical sample (N = 100)
Age	18–25: 45% 26–35: 33% 36–45: 8% 46+: 14%	18–25: 13% 26–35: 33% 36–45: 31% 46+: 22%
Gender	Female: 59%	Female: 44%
Employment	Full time: 38% Part time: 21% Student: 30% Unemployed: 11%	Full time: 0% Part time: 10% Student: 3% Unemployed: 74%
Highest level of education	Incomplete secondary school: 5% Completed secondary school: 6% Degree or diploma: 90%	Incomplete secondary school: 54% Completed secondary school: 10% Degree or diploma: 36%
Marital status	Single: 58% Married: 39% Divorced/separated: 5%	Single: 60% Married: 10% Divorced/separated: 22%

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