ORIGINAL ARTICLE

Positive Orientation and Psychological Distress: An Examination with Psychiatric Outpatients

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ABSTRACT

Introduction: This research was conducted to extend the theoretical construct of positive orientation (PO) to psychiatric outpatients. This research also examined the effect of PO on alleviating stress, anxiety, and depression among psychiatric outpatients. **Methods:** This cross-sectional survey recruited 301 psychiatric outpatients online. As these respondents have a short attention span, short measures were used to measure PO-related variables (life satisfaction, optimism, self-esteem) and indicators of psychological distress (depression, anxiety, and stress). These outpatients are at the legal age to provide consent for themselves (M = 30.12, SD= 8.11). The majority of them have been identified as male (80.07%). Similarly, the ethnic distribution was unequal, with the majority of these outpatients identified as Malay (85.05%), followed by those who were identified as Chinese (7.31%), Indian (4.32%), and from other ethnic groups (3.32%). **Results:** Generalized structured component analysis (GSCA) supported that satisfaction with life, optimism, and self-esteem reflect the construct of PO. Furthermore, PO predicted depression, anxiety, and depression negatively. **Conclusion:** It is possible to replicate the construct of PO with psychiatric outpatients using single item measures for life satisfaction, optimism, and self-esteem. PO is beneficial to psychiatric outpatients as it reduces the severity of depression, anxiety, and stress.
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INTRODUCTION

Through the inclusion of mental health in the UN Sustainable Development Goals that prioritize its global development, the United Nation has acknowledged the significance of mental health (1). Consistent with this effort, WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health was launched by the World Health Organization in 2019 to address the divided access to mental health care (2). In Malaysia, mental health remains a significant issue. The prevalence rate for mental health issues is the highest for individuals who are between 16 and 19 years old, and it was estimated that 1 in 3 Malaysians have faced mental health issues (3). In 2019, approximately half a million Malaysians were found experiencing symptoms of depression (4). Given the increasing prevalence of mental health concerns and the shortage of professional service providers in Malaysia (e.g. 5), it is possible to foresee the mental health sector becoming overwhelming. To prevent overwhelming the healthcare sector in Malaysia, it is imperative to explore possible ways to improve the clinical progress of existing clinical patients. This research proposed the positive orientation, which is an existing internal predisposition that promotes resilience (6).

To progress current literature and address the stated concern, this research was conducted with psychiatric outpatients. In a country that stigmatized mental health issues, individuals who had been diagnosed with clinical concerns faced challenges without adequate support (7), making it important for them to be independent and resilient. Positive orientation (PO) underlies self-esteem, life satisfaction, and optimism, making it a common feature for these predispositions (6). This trait-like theoretical construct is fundamental to individuals' evaluations of themselves, their lives, and their futures (6, 8-10), which will increase their self-efficacy and boost their adaptiveness (9, 11). In general, PO represents a basic disposition that empowers individuals in facing major challenges, as it reflects on individuals' capacities to reflect upon experience and to regulate thoughts and emotions (12). Hence, the protective aspect of this disposition against indicators of psychological distress is anticipated.

The adaptiveness of PO has been demonstrated in the literature, where individuals with a high level of PO experienced better job performance (11, 13-14), and were more likely to exhibit extra-role performance (13), which translates into better organizational citizenship (15). Consequently, these individuals tend to experience higher job satisfaction (16). PO that increases self-efficacy is protective against negative outcomes (9, 15, 17-20), and is capable of empowering individuals to cope with negative physical conditions (21-24) and psychological discomfort (24). PO also contributes to a better prognosis of physical ailments by improving patients' endorsement of health promoting behaviours (24). Given the high adaptability, individuals with high PO are inclined to appraise their lives as positive and tend to inflate their self-worth (6, 19, 25). Empirical findings also supported the stability of the theoretical construct of PO. This predisposition is embedded within human genetics (26), rendering it stable across different developmental stages (27, 28). This stability is adaptive across developmental stages, as PO functions to sustain and prolong the positive affect experienced (22). This inclination is adaptive, as it empowers individuals to manage stressful life events (28). Findings also support the notion that the construct of PO is replicable across cultures (25, 29). This finding further asserts its stability. A recent finding has supported the idea that PO can be nurtured by introducing a highly supportive environment (30). This feature is essential, as it indicates that this predisposition can be inculcated with proper simulation. This translates into an important practical implication in a clinical setting, that it is possible for practitioners to train their clients to be adaptive.

Overall, it is evident that the development of PO is integral. Upon deprivation of the capability to sustain positive emotions, engagement, and self-efficacy, individuals will lack the capacity to cope with challenges and stressful moments (12). Therefore, PO is a fundamental psychological construct that ensures adjustment and functioning (6). The present research intends to extend the scope of the application of PO, given that existing findings have consistently demonstrated its benefits in different settings (e.g. healthcare, 22; workplace, 17).

The focus of this research is on the conceptual link between PO and health-related outcomes. Existing findings have supported the adaptive aspects of PO, as illustrated by its inverse relationship with depression (25, 29) and stress (24). It was theorized that individuals with a high level of positivity were characterized by a state of positive affect (19), as supported by findings on its conceptual link with emotional stability (19, 31). This orientation facilitates adjustment among individuals with severe physical ailments, as demonstrated by a sample of cancer patients; those with higher levels of PO reported less physical and psychological discomfort (21). Similar results were found with patients with faecal continence (23) and chronic movement disorder (32); PO enhanced their physical and mental health (23) and increased their endorsement of healthy behaviors (32). These findings imply the benefits of PO on health outcomes and adjustment. As it induces a state of emotional stability (19, 31), PO maintains a state of positive affect (20) that increases resilience (9, 11). This tendency consolidates its protective features against negative thoughts and feelings of hopelessness (23). Overall, research findings have consistently demonstrated the benefits of PO on vulnerable populations.

As a construct that contradicts Beck's cognitive triad (negative views on self, the world, and the future), PO, which is formed by life satisfaction, optimism, and self-esteem, correlated negatively with the severity of depression (25, 29). The effect size suggests that PO correlated mildly with the severity of depression (25, 29), implying that PO and depression do not reflect a polarized relationship. PO that reflects resiliency (e.g. 9) is also protective against anxiety and stress (e.g. 25). Although the literature has clearly stated the benefits of PO, it is imperative to examine it with a different sample. The consistency of this construct has been supported across cultures (25, 29) and basic demographics (22). Still, empirical findings suggest that the saliency of PO may vary according to the context (25, 29). Therefore, it is possible that a specific context may suppress the development of PO, especially in the environment in Malaysia that lacks of social support (7) which undermines the fundamental positive affect that regulates this predisposition (22). This will increase an individual's susceptibility to aversive psychological experiences, such as depression and other clinical concerns. In this light, it is highly plausible that psychiatric outpatients may have a disrupted sense of PO, making them vulnerable to these clinical concerns.

This research aims to extend the theoretical investigation of PO using psychiatric outpatients. Existing findings have supported the replicability of this construct with samples other than university students (e.g. cancer patients; 22). Thus, this research will explore if the construct of PO is replicable with psychiatric outpatients who have been diagnosed with clinical symptoms. Previous findings have supported the notion that PO is an internal predisposition that enables individuals with severe medical conditions to adapt (e.g. 24). This research will be a significant extension to these findings; empirical findings have supported the benefits of PO on psychological well-being (e.g. 26), which is a prospect to improve the clinical progress of those with significant clinical concerns. This attempt will be conducted using a single-item indicator for each relevant construct (self-esteem, optimism, and life satisfaction), since individuals with clinical diagnoses have limited cognitive (e.g. 34) and attention span (e.g. 35). Given that this predisposition is beneficial to psychological well-being (e.g. 30), this research sought to investigate the protective effect of PO on various indicators of psychological distress.

Hence, this research has the following impacts: Firstly, it is addressing a gap in the literature, in which most empirical findings were derived from the public (e.g. 6), with the exception of a few that involved individuals with severe medical conditions (e.g. 24). The construct of PO has yet to be examined with individuals with clinical conditions, despite the availability of empirical findings on its effectiveness in alleviating psychological distress (e.g. 26). Secondly, upon validating the benefits of PO with clinical patients, it is possible to design interventions to inculcate the stated predisposition to ensure better clinical progress. This will enable these individuals to manage challenges resulting from the diagnosed symptoms as well as those resulting from the lack of social support in this society (7).

MATERIALS AND METHODS

A total of 301 psychiatric outpatients participated in this research. They were all adults who can legally provide consent to participate in this research. The majority of them were identified as male. The ethnic distribution was unequal, with most of the participants identifying as Malay, followed by Chinese, Indian, and another ethnicity. Most of them have been diagnosed with depression. Table I summarizes the demographic characteristics of these participants.

These individuals responded to an advertisement posted by a survey company in Malaysia. This survey was conducted in English. It is appropriate to use these measures in English, as it is widely understood and has been the main language used for content delivery in tertiary education institutions in Malaysia (35). This research was open to Malaysians who are 18 and older, and they must have been diagnosed with a clinical disorder by a certified practitioner. Participation was on a voluntary basis. Consent to participate was implied, whereby participants provided consent through the submission of their responses. This is to ensure anonymity, so that these individuals are not identifiable. Brief measures were utilized, as empirical research has indicated the limited cognitive (34) and attention span (35) of individuals diagnosed with clinical disorders. Ethics clearance was granted by the [blinded for review].

Data analysis was conducted with generalized structured component analysis (GSCA; 36, 37). This statistical method estimates three sub-models; the measurement model that estimates the relationships between the components and the indicators; the structural model that specifies the relationships among the components; and the weighted relation that defines components as weighted sums of their indicators (see 36 and 37). The overall goodness-of-fit measure, which is the FIT value, provides details on the explanatory power of components and indicators for the entire model, while the Goodness of Fit Index (GFI) and Standardized Root Mean Squared Residual (SRMR) inform the discrepancies between the sample and model-implied covariances (36, 37). For the current sample size of 301, the following criteria were used to determine the model fit: GFI ≥ .93 and SRMR ≤ .08 (see 38). A 95% bootstrapped percentile confidence interval (CI) with 5000 replications was calculated. A parameter estimate is considered significant at the 0.05 alpha level if the CI range does not include the value zero. Depending on the value estimated, the effect size (f2) of the estimated pathways will be interpreted as small (f2 = 0.02), medium (f2 = 0.15), or large (f2 = 0.35), respectively (see 39).

Table I: Participants' Demographics

Variables	*n* (%)
Age[a]	30.12 (8.11)
Gender	
Male	241 (80.07)
Female	60 (19.93)
Ethnicity	
Chinese	22 (7.31)
Malay	256 (85.05)
Indian	13 (4.32)
Others	10 (3.32)
Education level	
Primary level	2 (.66)
Secondary level	28 (9.30)
Tertiary level	267 (88.70)
Refused to disclose	4 (1.33)
Employment	
Full-time	128 (42.52)
Part-time	31 (10.30)
Unemployed	142 (47.18)
Diagnosis	
Attention deficit hyperactivity disorder	8 (2.66)
Adjustment disorder	1 (.33)
Anxiety disorder	68 (22.59)
Binge eating	2 (.66)
Bipolar disorder	43 (14.29)
Borderline personality disorder	11 (3.65)
Depression	111 (36.88)
Dissociative identity disorder	1 (.33)
Dysthymia	1 (.33)
Hypersomnia	1 (.33)
Insomnia	16 (5.32)
Obsessive-compulsive disorder	7 (2.33)
Obsessive-compulsive personality disorder	1 (.33)
Panic attack	1 (.33)
Posttraumatic stress disorder	9 (2.99)
Schizophrenia	13 (4.32)
Social anxiety	1 (.33)
Unwilling to disclose	6 (1.99)

Note: [a] The mean and standard deviation were reported instead of frequency. The standard deviation was reported in brackets.

Measures

The Screening Tool for Psychological Distress (STOP-D)

is a five-item measure, with one item assessing the psychological constructs of depression, anxiety, stress, anger, and social support (40, 41). Each item is a stand-alone item that reflects on different aspects of psychological distress. These five items were rated on a 5-point scale (1 = Not at all, 5 = Severely). For this research, the items for depression, stress, and anxiety were used.

Self-esteem was measured using a single item (Single-Item Self-Esteem Scale; 42). This item (e.g. I have high self-esteem) was rated on a 5-point scale (1 = Not very true of me, 5 = Very true of me). This item was highly correlated with the Rosenberg Self-Esteem Scale (44), supporting that this single item indicator of self-esteem reflects the similar construct measured by the Rosenberg Self-Esteem Scale (43). Additionally, this single item was positively correlated with other indicators of functioning and was negatively correlated with depression and perceived stress (42).

Life satisfaction was measured using a single item, "In general, how satisfied are you with your life?" (44). This item was rated on a 5-point scale (1 = Very dissatisfied, 5 = Very satisfied). This item was highly correlated with the Satisfaction with Life Scale (45), supporting that this single item reflects the similar construct measured by the Satisfaction with Life Scale (45).

Optimism was measured with the single item that reflects optimism (Scale Optimism-Pessimism-2; 46). This single item (e.g. How optimistic are you in general?) was rated on a 5-point scale (1 = Not at all optimistic, 5 = Very optimistic). It was positively correlated with the Life Orientation Test-Revised (47), supporting that the single item and the Life Orientation Test-Revised (47) reflect on the same construct.

RESULTS

The weight and loading for each item were first inspected. These details are available in Table II. The weights and loadings were all significant, indicating that optimism (R^2 = 0.56), self-esteem (R^2 = 0.69) and life satisfaction (R^2 = 0.69) contributed significantly to the formation of a latent construct. This construct is interpreted as positivity or PO (α = 0.73). Results indicated that this latent variable significantly predicted the severity of depression (β = -0.35, SE = .06, 95% CI [-.47, -0.21], f2 = .14), stress (β = -0.23, SE = 0.06, 95% CI [-0.35, -.10], f2 = 0.05) and anxiety (β = -0.20, SE = 0.06, 95% CI [-0.33, -0.08], f2 = 0.04). These results indicated that a higher level of positivity is protective against depression, stress and anxiety. From these effect sizes, positivity or PO is much more effective in reducing depression than stress and anxiety. The FIT value is 0.51, indicating that the entire GSCA model accounted for 51% of variance. The fit values (GFI = 0.98, SRMR = 0.05) indicated that the model fit the data well.

Table II: Weights and Loadings for the GSCA Model

Variables	Weight		Loading	
	β (SE)	95% CI	β (SE)	95% CI
Optimism	.31 (.04)	[.23, .38]	.75 (.05)	[.62, .83]
Self-esteem	.43 (.03)	[.36, .47]	.83 (.02)	[.78, .87]
Life satisfaction	.49 (.04)	[.44, .58]	.83 (.02)	[.75, .87]

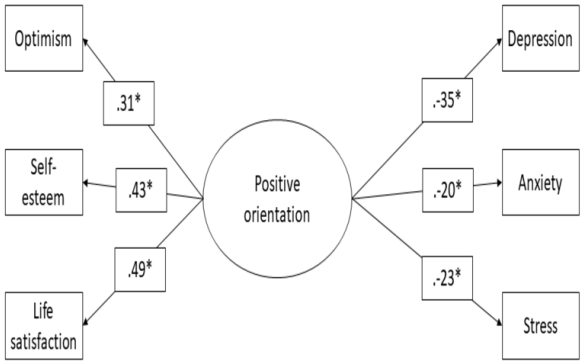

Figure 1: GSCA model predicting indicators of psychological distress with positive orientation. All indicators were significant.

DISCUSSION

This research was conducted to address a gap in the literature, which is the fixation on student samples that limits the practical application of PO. This research replicated the construct of PO with a sample of psychiatric outpatients and examined its relevance as a protective factor against indicators of psychological distress. The obtained findings support the robustness of this theoretical construct across samples. Initial results complimented previous findings as PO was found protective against depression (25, 29), anxiety (24), and stress (24, 32). In sum, PO is a psychological construct that can inhibit these aspects of psychological distress. PO can be an integral personal resource that optimizes individual's function (24). In general, these findings support the notion that individuals with low levels of PO tend to experience aversive psychological experiences as they are less likely to experience positive aspects of life (6). Empirical findings suggest that the development of PO is conditional upon macro-level factors or the environment in which an individual resides (25, 29). As the environment in Malaysia does not foster a suitable climate for psychiatric outpatients (e.g. 5, 7), it is possible to expect that these individuals have a disrupted sense of PO. This assumption is negated by current findings. Results from GSCA indicated the presence of PO amongst the recruited psychiatric outpatients, with each of the corresponding indicators loading significantly on the hypothesised construct. This supports the interpretation of PO as a form of individual differences (6) or as a form of mental resources to cope with challenges (24). Although the results did not support the disrupted sense of PO

amongst these psychiatric outpatients, it is possible that they have a less salient PO compared to those who have not yet been diagnosed with any clinical concerns.

This research has successfully replicated the construct of PO with a different structural equation modelling method, supporting the robustness of this theoretical construct. Each indicator contributed a substantial amount of variance to the latent construct, implying that this orientation underlies self-esteem, optimism, and life satisfaction. This result extends the idea that even with a single-item indicator for self-esteem, optimism, and life satisfaction, it is possible to replicate the construct of PO. This is a significant contribution of this research, as it has proven that it is possible to examine the construct of PO with limited items, especially when the participants have limited capacity to respond to longer surveys (e.g. 34). As indicated by the effect sizes, each of these indicators contributed a significant amount of variance to the construct of PO. Hence, it is unlikely that this construct was found due to a statistical artefact. Rather, it reflects meaningful interrelationships among these indicators.

This result conveys that individuals with a high PO are able to alleviate depressiveness (24, 29); stress (22, 24, 32) and anxiety (24). This highlights the protective feature of PO and its application in a clinical setting. The moderate to weak effect sizes suggest that this predisposition has limited direct effect on these outcomes. Therefore, it is possible that PO increases the saliency of certain adaptive behaviors that are effective in reducing the saliency of depression, stress, and anxiety. The benefits of PO on psychological well-being may be embedded in its ability to sustain the state of positive affect (25, 31). The construct of PO fixes individuals' concentration on the present, after accounting for some positive aspects of their past and future (49), and this tendency has been adaptive for those with severe physical ailments (e.g. 23). Therefore, the capacity to maintain a state of positive affect is fundamental to the adaptiveness of PO (25). As these aspects are beyond the present scope, validation from upcoming research is required. As PO can be nurtured (30), it is possible for practitioners to instil the relevant tendencies (self-esteem, optimism, and satisfaction with life) in clinical patients. Another good instance is to direct relevant positive experiences from the past and future to cope with the present situation (48). The invention of effective interventions to consolidate the state of PO can be a promising area for upcoming research.Results indicated that the direct effect of PO on depression was stronger than stress and anxiety, which is similar to previous findings (24, 25, 29). This finding is consistent with the conceptualization of PO, which was based on Beck's cognitive triad that accounts for depression (6). This construct was proposed as an inclination that contradicts depression. The small to medium effect size accounted for by the direct effect of PO on depression suggests that this relationship is not a polarized one; that the presence of PO directly contradicts the presence of depression. The moderate effect size implies the presence of complex psychological mechanisms underlying this direct relationship. As anxiety can be conceptualized as a form of strong state of affect (49), PO is effective in managing it as well. The weak to moderate effect size of the direct effect of PO on anxiety is consistent with the earlier finding that the presence of PO may not entirely negate the existence of anxiety. This corresponds to the conceptualization of PO as a form of predisposition (6) or personal resource (24). This tendency operates through a complex psychological mechanism by reducing the saliency of negative affect, possibly by promoting other tangible behaviours. Results also supported the notion that PO is protective against stress, as those with a high level of PO tend to endorse effective strategies in stress management and are more resilient against negative emotions (32). This is consistent with the findings on its protective effect on depression and anxiety, which both are marked by negative emotions. This consolidates the findings of this research: PO is beneficial to the psychological well-being of psychiatric outpatients.

Theoretically, the construct of PO, or positivity, is replicable with psychiatric outpatients with formal diagnoses. This finding supports the universality of PO as a form of innate predisposition that enables individuals to be adaptive. Apart from increasing resilience against physical medical conditions (e.g. 23), PO enables psychiatric outpatients to cope with psychological issues such as depression, anxiety, and stress. These findings are a significant extension to PO, in which most findings describing the psychological benefits of PO were derived from general populations (e.g. 6). These findings support the adaptiveness of PO as illustrated with the normal, healthy population; it enables individuals with clinical diagnoses to adapt against depression, anxiety, and stress. As a result, by consolidating the stated state of positivity, it is possible to improve clinical progress of psychiatric outpatients. Similarly, it is possible to anticipate a patient's clinical progress by observing the state of positivity. However, this aspect requires further validation, as the treatment prospect is conditional upon multiple factors. Additionally, the underlying psychological mechanisms remained unexplored, given the exploratory nature of the present scope.

Another possible direction for upcoming research is the comparison of PO between individuals with and without clinical diagnoses. As a predisposition that reduces vulnerability to psychological distress, individuals with clinical diagnoses should have a lower level of PO compared to those without clinical diagnoses. This resonates with the current issues faced in Malaysia, including the shortage of professional staff (5) and stigmatization of mental health issues that marginalized this vulnerable population (7). These factors contribute to an environment that is not suitable to foster a suitable

climate for PO (e.g. 30). Hence, theoretically, the PO level of psychiatric outpatients with formal clinical diagnoses should be lower than that of those without clinical diagnoses. The weakened trait of PO that is protective against psychological distress increases the vulnerability to mental health issues. Therefore, the saliency of PO within an individual can be a marker of the current state of psychological well-being. Practically, it is possible to conduct a quick screening using the items used in this research. Additionally, it is imperative to extend the current scope. This extension may include the examination of societal-level variables that influence the development of PO. Although past findings have supported the stability of this construct across countries (e.g. 25, 29) and across lifespan (27, 28), the different mean scores found imply that the saliency of PO is conditional upon certain macro-level indicators, such as culture. Insights from this scope can be used to foster a suitable climate that promotes the saliency of PO, possibly at a larger scale, which will eventually translate into higher resiliency against upcoming challenges.

Another point that requires further examination is the stability of PO. The heredity aspect of PO (26) indicates that it has a stable developmental trajectory (27, 28). These findings indicate that PO itself could be a fixed inclination. At birth, the saliency of PO has been determined. This implies that, upon birth, individuals with a weak state of PO are susceptible to clinical concerns. There is nothing that can be done to prevent these individuals from developing clinical concerns such as depression. However, subsequent developments suggest the possibility of fostering this inclination to consolidate the existing state of resilience. As mentioned, PO can be nurtured (30), indicating that this inclination is conditional upon environment. Therefore, certain environments, such as societal factors like culture (25, 29) and familial support (30), may affect the development of PO. It is theoretically possible that psychiatric outpatients have been exposed to environments that weakened the development of PO. This indicates that the development of PO itself is a complex process. The heredity aspect of PO is conditional upon environments that foster a proper climate for its development. In a society that stigmatizes individuals with clinical concerns, it is reasonable to expect that these psychiatric outpatients have been exposed to a hostile environment that inhibits the development of PO. The hindered development of PO may contribute to their susceptibility to clinical issues, thereby delaying their clinical progress. This implies that the effort of consolidating PO among the public should be shared between mental health practitioners and other stakeholders (e.g. government agencies). Consolidating the state of PO at the individual level may be futile, as a hostile environment may suppress its development. This interaction of the heredity aspect of PO and the environments is promising and requires further examination.

This research has a few evident limitations. Findings derived from the present cross-sectional survey could not be interpreted causally. Therefore, the directionality of the findings is questionable. A longitudinal design may shed more theoretical perspectives, as this design can elaborate on the changes in the conceptual relationships over time. Responding bias could be an issue, since this research utilized self-report measures. However, it is imperative to do so, since the recruited participants may have difficulties sustaining their attention (e.g. 34). In addition, the formation of PO using brief measures, as justified by current results from the GSCA model, supports the robustness of this construct. Therefore, utilizing brief measures is unlikely to contaminate the present findings. Instead, it has contributed to progressing current knowledge on this disposition. It is possible that the primary diagnosis of these clinical patients has contaminated the findings. Standardizing the primary diagnosis may ensure consistency of the findings and enhance their practical implications. The effect sizes from the main analysis suggest that the predictors involved have limited influences on the outcomes. Therefore, upcoming research should consider other variables that may have more influence on the indicators of psychological distress. Another limitation of this research is the severity of the diagnosed conditions. Although the respondents have declared that they have received a formal diagnosis, it is highly possible that they are experiencing milder symptoms. In this light, the current results may not be fully applicable to those who are experiencing severe conditions. Hence, a comparison with a sample without a formal diagnosis and a sample of inpatients with severe conditions may provide significant perspective to the theory of PO: that healthy individuals tend to have a higher level of PO.

CONCLUSION

This research concludes that the theoretical construct of PO is replicable with psychiatric outpatients and is protective against depression, anxiety, and stress. Therefore, PO is a predisposition that can be beneficial to improving psychiatric outpatients' clinical outcomes.

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