

## Insight, distress and coping styles in schizophrenia

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### Abstract

**Background:** The stigma and negative societal views attached to schizophrenia can make the diagnosis distressing. There is evidence that poor insight into symptoms of the disorder and need for treatment may reflect the use of denial as a coping style. However, the relationships between insight and other coping styles have seldom been investigated.

**Method:** We examined the associations between insight, distress and a number of coping styles in 65 outpatients with schizophrenia (final  $n=57$ ) in a cross-sectional study.

**Results:** We found that (i) awareness of symptoms and problems correlated with greater distress, (ii) 'preference for positive reinterpretation and growth' coping style correlated with lower distress and with lower symptom awareness (re-labelling), (iii) 'preference for mental disengagement' coping style correlated with greater distress and lower awareness of problems, and (iv) 'social support-seeking' coping style correlated with greater awareness of illness, but not distress. No relationship occurred between the use of 'denial' as a coping style and insight or distress.

**Conclusions:** Our findings demonstrate that awareness of illness and related problems is associated with greater distress in schizophrenia. However, this investigation has not supported a simple psychological denial explanation for this relationship, as complex relationships emerged between different dimensions of insight and coping styles. The negative association between 'positive reinterpretation and growth' and distress suggests that adopting this style may lead to re-labelling symptoms in a less distressing way. Avoidant and isolating styles of coping both appear unhelpful. Psychological interventions should aim to promote more active coping such as discussing a mental health problem with others.

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**Keywords:** Insight; Schizophrenia; Coping; Social support; Positive interpretation

### 1. Introduction

People diagnosed with schizophrenia frequently disagree with their friends, relatives and clinicians about

whether they are mentally ill, whether their experiences and behaviours are abnormal, and whether they are in need of psychiatric treatment such as medication. Such disagreements are widely held to reflect poor insight on the part of the patient; insight dimensions typically include awareness of illness, awareness of symptoms, and recognition of the need for treatment, respectively (David, 1990). Poor insight is sometimes seen as just another symptom or manifestation of the disorder (Cuesta and

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Peralta, 1994). However, another conceptualisation is that poor insight represents an individual response to the diagnosis of schizophrenia.

Schizophrenia is a highly stigmatising disorder (Thornicroft, 2006). Many individuals with this diagnosis feel devalued and discriminated against as a result (Dickerson et al., 2002). Societal, and sometimes medical, views include the belief that it is a chronic, debilitating condition from which individuals have little chance of recovering (Angermeyer et al., 2004). This conceptualisation can be threatening and distressing to those given the diagnosis, and is likely to contribute to the high level of depression experienced by many people with schizophrenia (Mulholland and Cooper, 2000). One way in which individuals might cope with this situation is by denial (for review see Goldbeck, 1997), leading to poor insight.

A link between denial as a coping mechanism and poor insight was suggested shortly after schizophrenia was first delineated, when Mayer-Gross (1920) identified ‘denial of the psychotic experience’ as one of the strategies adopted by patients with schizophrenia, in that, typically, they were unaware of the symptoms of the illness (i.e. lacked insight). The seminal review of Amador et al. (1991) highlighted the denial of illness through psychological coping mechanisms as a potential aetiological model of poor insight in schizophrenia. More recently, poor insight has again been hypothesised to reflect the use of a psychological defence mechanism in the form of denial of illness (Moore et al., 1999). Implicit in all of these models is the concept that denial serves to protect the individual from the distress which acknowledging the presence of illness would cause (Moore et al., 1999).

The psychological denial model predicts that those who deploy denial as a coping strategy will have poorer insight, but will suffer less distress. Indeed, a number of cross-sectional studies support a relationship between higher insight and greater distress, including depression (meta-analysis, Mintz et al., 2003), hopelessness (Carroll et al., 2004), and suicidality (Schwartz and Smith, 2004). Furthermore, longitudinal studies have also shown that as insight increases, both depression (Carroll et al., 1999) and suicidal ideation (Cunningham Owens et al., 2001) worsen. These studies led Schwartz (2001) to hypothesise that there is a chain of causality from insight, to demoralisation, to depression, to suicidality. A study using structural equation modelling (Drake et al., 2004) has also found evidence for the direction of causality proceeding from increasing insight to greater depression.

Although these relationships between insight and distress are consistent with the psychological denial

model, they do not test the model explicitly. To test the hypothesis that the use of denial is directly related to poor insight, it is necessary to measure coping styles (including denial) directly. A number of studies have addressed this question, and have found associations between coping styles and insight in schizophrenia. Greater ‘self-deceptive positivity’ (the tendency to give self-reports that are honest but positively biased) has been linked to lower awareness of illness, while greater ‘impression management’ (deliberate positive self-presentation to an audience) has been linked to lower past awareness of illness, its social consequences, and the effects of medication (Moore et al., 1999). These results are interpreted by the authors as suggesting that clinical insight is, at least in part, a function of denial (Moore et al., 1999). However, denial is only one of the many ways that people cope with problems, and the above studies did not investigate other coping styles. More recently, Lysaker et al. (2003a) looked at the relationships between specific dimensions of insight and preference for particular coping styles in schizophrenia. A preference for using ‘escape-avoidance’ as a coping style was related to lower awareness of the consequences of illness, while greater preference for ‘positive reappraisal’ was correlated with lower awareness of symptoms (Lysaker et al., 2003a). However, this study did not look at how these relationships related to distress.

The present study aimed to examine the associations between insight, distress, and coping styles in a sample of people with a diagnosis of schizophrenia. Following the psychological denial model, we hypothesised that poor insight would be associated with both the use of denial as a coping strategy and less distress. We also examined the relationships of insight and distress to 14 other coping styles (see Section 2.2), in addition to the use of denial, as measured by the COPE (Carver et al., 1989). Of these 14 styles, ‘positive reinterpretation and growth’ corresponds most with the ‘positive reappraisal’ dimension assessed by the Ways of Coping Questionnaire (WCQ, Folkman and Lazarus, 1988; used in Lysaker et al., 2003a), while ‘behavioural disengagement’ reflects avoidance. Based on the observations of Lysaker et al. (2003a), we predicted that ‘positive reinterpretation and growth’ and ‘behavioural disengagement’ would both correlate with lower insight, with the latter correlating most strongly with ‘awareness of symptoms’ and the former with ‘awareness of illness’ dimensions within the David’s model of insight. Although no study to our knowledge has investigated ‘positive appraisal’ or ‘avoidant’ coping styles in relation to distress in schizophrenia, previous studies in people with physical illnesses suggest reliable associations between ‘approach’ styles of coping and

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