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Insight into mental illness and self-stigma: The mediating role of shame proneness

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ABSTRACT

Insight into mental illness and self-stigma among persons with serious mental illness (SMI) have been found to be related, but the process behind this relation is still unclear. The current study examined whether shame and guilt proneness mediates or moderates the relation between insight into mental illness and self-stigma among persons with SMI. Sixty persons with SMI completed questionnaires that assessed their insight, shame, guilt proneness, and self-stigma. Results reveal that shame proneness but not guilt proneness mediates the relation between insight and self-stigma. The theoretical and clinical implications of the differences between shame and guilt and their relation to the development of self-stigma are discussed.

1. Introduction

Research has shown that approximately 50–80% of persons with schizophrenia exhibit varying degrees of lack of insight into their illness (Amador et al., 1991, 1994). Lack of insight is defined by unawareness of the illness label, the need for treatment, and the illness implications (Amador et al., 1991). There is much controversy regarding the impact of lack of insight. On one hand, lack of insight has been found to be related outcomes such as lower levels of treatment adherence (Cuffel et al., 1996; Olfson et al., 2006), clinical outcome (Schwartz, 2001) and poorer social function (Lysaker et al., 1998; Francis and Penn, 2001). On the other hand, high insight has been associated with different undesirable outcomes. Accumulating evidences reveal that, among persons with serious mental illness (SMI), insight into illness is related to negative outcome such as lower hope, lower self-esteem, lower quality of life, depression and suicide attempts (Amador et al., 1996; Schwartz et al., 2006; Hasson-Ohayon et al., 2006, 2009). These relations have been recently suggested to occur via self-stigma, the process in which one internalizes the public stigma of mental illness over oneself (Lysaker et al., 2007a; Staring et al., 2009).

For example, Lysaker et al. (2007a) reported that persons with high insight who endorsed internalized stigma beliefs had lower levels of self-esteem, hope, and fewer interpersonal relationships than those with insight who rejected stigmatizing beliefs. Similarly Staring et al. (2009) found that the relation between insight and depression, low quality of life, and negative self-esteem are moderated by stigma. The hypotheses that self-stigma explains the negative effects of insight were also supported in a recent study which focused on parents of persons with SMI (Hasson-Ohayon et al., 2011). That study showed that parents self-stigma mediates the relation between their insight into their relatives illness and their experience of family burden (Hasson-Ohayon et al., 2011).

Understanding factors that contribute to self-stigma is important since an internalized stigma was found to be related to treatment participation (Tsang et al., 2010), hope and self-esteem (Lysaker et al., 2007a). Various factors have been hypothesized to be related to the process of stigma internalization among persons with SMI. In a recent review Livingston and Boyd (2010) showed that there is no association between self-stigma and socio-demographic variables, and that self-stigma is related negatively to psychological outcome such as hope and empowerment. They also found that internalized stigma is related to severity of symptoms and treatment adherence (Livingston and Boyd, 2010). Little is known, however, about what contributes to the development of self-stigma. These possible contributors may explain why some people develop self-stigma while others do not.

Tangney (1995) suggested that most people possess the ability to experience both feelings of shame and guilt under different life

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circumstances. However, she argued that some people tend to react to negative experiences by feeling guilty (regarding a specific behavior) while others tend to react to similar experiences by feeling shame (regarding the self) (Tangney, 1995). These possible differences in the experiences of both shame and guilt are thought to be related to processes of adjustment (Tangney, 1995) and may impact upon the relation between insight into the mental illness and self-stigma.

Both feelings of shame and guilt are often reported by persons with SMI and their family members (Corrigan and Miller, 2004; Miller and Mason, 2005), and are related to the mental illness stigma (Miller and Mason, 2005; Hinshaw, 2007). Studies have shown that feelings of shame are related to low probability of rejecting the stigma (Rüsch et al., 2010) and low self-esteem and quality of life (Rüsch et al., 2007a). Feelings of guilt were found to be positively correlated with insight into the illness (De Hert et al., 2009).

Based on the above reviewed literature, suggesting relations between insight, self-stigma, shame and guilt, the current study attempted to clarify these relations in order to better understand the process by which insight impacts upon self-stigma. Understanding this process may lead to improving the services provided for persons with SMI, especially those interventions which are focused on self-stigma (i.e. Narrative enhancement and cognitive intervention, Yanos et al., 2011). To achieve this goal we examined whether shame and guilt proneness mediate or moderate the relation between insight and self-stigma. Specifically we tested the following four conditions of a mediating model (see Baron and Kenny, 1986 conditions for mediation): (1) insight and self-stigma will be positively correlated, (2) insight and feelings of shame and guilt will be positively correlated, (3) self-stigma and the tendency for shame and guilt will be positively correlated, (4) reduction of the positive relationship between insight into the mental illness and self-stigma when the covariance between insight into the mental illness and the tendency for shame and guilt is statistically controlled for. In addition we tested a moderating model by testing the hypothesis that for persons with high shame and guilt proneness a positive relation between insight and self-stigma will be found, while for persons with low shame and guilt proneness no relation will be found between insight and self-stigma.

2. Method

2.1. Research participants

Participants consisted of 60 people with a serious mental illness who availed inpatient and outpatients psychiatric services at the Sheba Medical Center in Israel. Diagnoses (DSM-IV) were determined on the basis of the medical file and clinical interview carried out by a psychiatrist. Table 1 presents the demographic and diagnostic characteristics of the study sample. As can be seen in Table 1, the majority of the participants were inpatient (61.7%), unemployed (73.3%), had a diagnosis of schizophrenia (66.6%) and were single or divorced (66.6%). The socio-demographic and medical status data were not related to the study variables. Approximately 50% patients from the inpatient unit and 50% from the outpatient unit participated in the study (estimation is based on the percentage of participants in relation to the number of patients attending the unit). Reasons for refusals to participate were unwillingness to participate in a pencil and paper assignment and low motivation for sharing and fear from no confidentiality.

2.2. Power considerations

In order to determine the sample size for the research, we used calculations based on Cohen's definitions for effect-size and power calculations (Cohen, 1977). All calculations were made using "G*Power" computer software (Faul et al., 2007). assuming a medium to large effect size ($f^2=0.25$) for R square increase in multiple regression analyses including four predictors, a sample of 60 is necessary to achieve at least 96.7% power, with an alpha level of 0.05.

Table 1
Demographic and psychiatric characteristics of the sample ($n=60$).

Variable	Category	*N*	%
Gender	Male	49	81.7
	Female	11	18.3
Marital status	Never married	32	53.3
	Married	19	31.7
	Divorced	8	13.3
	Widowed	1	1.7
Occupational status	Employed	16	26.7
	Unemployed	44	73.3
Main daily activity	Paid work	14	23.3
	Volunteering	2	3.3
	Studying	13	21.7
	Rehabilitation program	5	8.3
	Hobbies	6	10
	No routine activity	15	25
	Other	5	8.4
Diagnosis	Schizophrenia	40	66.6
	Schizoaffective	7	11.7
	OCD	1	1.7
	PTSD	4	6.7
	Major depressive	2	3.3
	Bipolar Disorder	6	10
Treatment status	Inpatient	37	61.7
	Outpatient	23	38.3
No. of hospitalizations	0–1	15	25
	2–4	17	28.3
	5–7	5	8.3
	8–10	4	6.7
	11 and up	19	31.7
Variable	Mean	S.D.	Range
Age	42.41	15.7	20–86
Time since initial diagnosis	16.27	12.85	0.1–50
Years of education	11.8	2.96	0–20

2.3. Instruments

2.3.1. Insight into mental illness

Insight into mental illness was assessed using Chopra's Hebrew translation (Chopra, 2004) of the Schedule for Assessment of Insight-Expanded Version (SAI-E) (Kemp and David, 1995, 1997). The scale is made up of three separate but overlapping dimensions of insight into mental illness: awareness of the illness, the capacity to re-label psychotic experiences as abnormal and awareness of symptoms, and treatment compliance. This questionnaire is made up of 10 probe questions (three items representing the first dimension, four representing the second, and three representing the third) which the participant is asked by the clinician. In addition, the SAI-E presents a hypothetical contradiction item. This item is used to evaluate the extent to which the participant takes into account the perspective of others who contradict the psychotic belief. Higher scores on the SAI-E items indicate higher levels of insight. Support has been produced for the validity of the original SAI-E (Sanz et al., 1998) and for the internal consistency of the Hebrew version (Chopra, 2004; Hasson-Ohayon et al., 2009). In the present study, the Cronbach alpha estimate of internal consistency for the total insight score was 0.72, and for awareness of the illness, re-labeling, and compliance, these estimates were 0.76, 0.63, and 0.62, respectively.

2.3.2. Internalized stigma

Internalized stigma was assessed by the Hebrew translation of the Internalized Stigma of Mental Illness Scale (ISMI) (Ritsher et al., 2003). This 29 items scale evaluates the subjective experience of stigma due to having a mental illness and has been found to be valid and reliable (Ritsher et al., 2003). In the present study, the Cronbach alpha estimate of internal consistency for the total internalized stigma score was 0.9. The ISMI provides five sub-scale scores. The Alienation subscale ($\alpha=0.82$) measures the subjective experience of being less than a full member of society. The Stereotype Endorsement subscale ($\alpha=0.5$) measures the degree to which respondents agree with common stereotypes about people with mental illness. The Discrimination Experience subscale ($\alpha=0.46$) captures respondents' perception of the way that they currently tend to be treated by others. The Social Withdrawal subscale ($\alpha=0.82$) measures the extent to which respondents