



Self-stigma and stages of change as predictors of treatment adherence of individuals with schizophrenia

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ABSTRACT

The current study aimed at exploring the relationship between self-stigma, readiness for change and psychosocial treatment adherence among individuals with schizophrenia. Between March 2007 and January 2008, 105 adults with schizophrenia were recruited for this cross-sectional study. Face-to-face interviews were conducted to assess participants' level of self-stigma, readiness for change, insight, and general self-efficacy. The corresponding case therapists reported participants' level of treatment adherence, psychopathology, and global functioning. Findings of stepwise multiple regression suggested that individuals with higher global functioning, better readiness for action, and lower level of self-stigma demonstrated better treatment participation. Individuals with lesser severity of psychiatric symptoms and female participants had better treatment attendance. The results of discriminant function analysis showed the combined score of self-stigma, stages of change, and global functioning measures correctly classified 76.2% participants into adherent/nonadherent group membership. Suggestions for further studies and development of self-stigma reduction program to facilitate recovery and treatment adherence were made.

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1. Introduction

Treatment adherence plays a vital role in psychiatric rehabilitation (Corrigan, 2004; Tsang et al., 2006). Unfortunately, poor adherence to medication and psychosocial treatment is prevalent among individuals with schizophrenia, which increases their likelihood of relapse and re-hospitalization (Swanson et al., 1997; Tay, 2007; McCann et al., 2008). Relapse is a costly event (Knapp, 2000), which led to an additional health expenditure of two billion in US (Weiden and Olfson, 1995). In addition, treatment non-adherence limits the dissemination of clinical services (Watson and Corrigan, 2001) to enhance independent living, employment, and quality of life among individuals with schizophrenia (Bustillo et al., 2001; Antai-Otong, 2003; Glynn, 2003).

Evidence-based psychosocial treatment such as vocational rehabilitation and cognitive behavioral therapy (Mueser and Bond, 2000; Glynn, 2003; Bellack, 2004) is essential to helping individuals attain recovery, independence, and life satisfaction (Antai-Otong, 2003). Fung and colleagues (2008) conducted a cross-sectional study to explore the relationship between self-stigma and psychosocial treatment adherence. The self-stigma, self-esteem, self-efficacy, insight, and psychosocial treatment adherence among 86 individuals with schizophrenia were assessed. The results revealed that high self-stigma, low self-esteem,

and poor insight were significant predictors of treatment adherence. Among these predictors, self-stigma was shown to be the strongest in terms of its prediction power. Self-stigma is defined as a self-discredit of individuals by internalizing negative stereotypes prescribed to them and/or their social group (Corrigan and Watson, 2002; Corrigan et al., 2006; Fung et al., 2007). Self-stigmatized individuals are likely to possess low self-esteem and poor adherence behaviors (Weiss and Ramakrishna, 2001; Fung et al., 2007). Our earlier study (Fung et al., 2008) has found that self-stigma is one of the contributing factors in undermining treatment adherence. The underlying linkage between the two constructs nevertheless has not been clearly demonstrated. We believe that certain self-stigmatized individuals might try to avoid unnecessary discrimination by not utilizing psychiatric services (Corrigan, 2004). Fung et al. (2008) suggested that these individuals may experience hopelessness, which may undermine the beneficial effects of treatment and lead to nonadherence. Individuals with schizophrenia often endorse a feeling of self-disregard and incompetence (Lysaker et al., 2008a,b). It may be possible that their self-stigmatized thoughts might therefore reduce their motivation and thus readiness for seeking and adhering to psychiatric services prescribed by the mental health professionals, as motivation is a crucial determinant to changing problematic behaviors (Miller and Rollnick, 2002; Barkhof et al., 2006) and improving treatment engagement (Mulder et al., 2005).

An evidence-based understanding on the relationship between self-stigma and treatment adherence should shed light on formulating intervention programs to resolve stigma-related problems and thus promoting the recovery of individuals with schizophrenia. The Stages of Change Model (SOC) has been widely adopted to study the

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readiness for change toward behavioral problems (Chou et al., 2004). Nonadherent behavior is regarded as a problem as it is one of the key obstacles for recovery. Studies have employed the SOC model to explain medication adherence among individuals with mental illness (Rusch and Corrigan, 2002; Finnell and Osborne, 2006). SOC model suggests that these individuals demonstrate four different stages in their help-seeking behaviors (Hilburger and Lam, 1999; Rogers et al., 2001; Chou et al., 2004), including pre-contemplation (no awareness of the problem in making change), contemplation (awareness of the problem, but without taking action for change), action (commitment of effort for change), and maintenance (prolonged efforts for avoiding re-occurrence of problems). It seems that self-stigmatized individuals are more likely to be affected by their social identity as suffering from schizophrenia. Their psychiatric illness causes them to develop a sense of hopelessness, which fixates them at the contemplation stage. They are therefore not ready to engage in psychosocial interventions such as supported employment and social skills training as prescribed by their case therapists. Individuals at the contemplation stage feel ambivalent. They realize the need to deal with their own psychiatric-related problems (Miller and Rollnick, 2002). Nevertheless, they are not motivated enough to engage themselves in treatment. By contrast, they demonstrate poor psychosocial treatment adherence.

The objectives of this study were to investigate the relationship between self-stigma, stages of change, and treatment adherence among the individuals with schizophrenia. It was hypothesized that individuals with lower level of self-stigma and better readiness for change are more likely to have better adherence on psychosocial treatment. The effects of general self-efficacy, insight, psychopathology, global functioning, and demographic characteristics on treatment adherence were also taken into account.

2. Method

2.1. Participants

After institutional ethical approval was obtained, 105 adults with schizophrenia (response rate = 87.5%) were recruited from the participating psychiatric day hospitals (i.e., United Christian Hospital and Yung Fung Shue Psychiatric Centre) and community settings (i.e., Baptist Oi Kwan Social Services, Richmond Fellowship of Hong Kong, and Stewards Company) between March 2007 and January 2008. The response rate was calculated as “total number of participants completed the questionnaires” dividing by “the total number of eligible participants referred to this study by the mental health professionals”. Lack of interest and being unable to answer the questionnaires were the two main reasons for their withdrawals. Fifty-four of the participants were female. The participants were aged from 20 to 64 years. On average, they were aged 41.83 years (standard deviation (S.D.) = 9.00). 72.38% were single, 9.52% were married, and 18.10% were divorced or widowed. 88.57% received social security allowance and/or disability allowance from the government. Participants did not have any developmental disabilities. All of them received psychosocial treatment such as vocational rehabilitation programs (e.g., supported employment, sheltered workshop training, and pre-vocational training), social skills training, cognitive behavioral therapy, and family intervention from the above psychiatric units. The psychosocial treatment offered by the psychiatric settings was primarily on daily basis, which formed an integral part of the treatment provided by the psychiatric team for both hospital and community settings. The percentage of attendance to psychosocial treatment of the participants varied substantially. Some attended every day whereas some were often absent. All participants had received at least elementary education, which was to make sure that they had adequate language ability to comprehend the questionnaires.

2.2. Instruments

The 17-item Psychosocial Treatment Compliance Scale (PTCS; Tsang et al., 2006) was used to measure participants' participation level (e.g., actively participated in prescribed psychosocial treatment) and attendance (e.g., attended prescribed psychosocial treatment on time) toward the prescribed psychosocial interventions. The two subscales are rated on a 5-point Likert scale ranging from “(1) never” to “(5) always” through the daily clinical observation by the cases therapists for the past 3 months before the commencement of interview. Adherent participants would obtain higher summated scores on the subscales of PTCS. Excellent internal consistency ($\alpha = .87-.96$) and test-retest reliability ($ICC = .86-.90$) were reported for the subscales (Tsang et al., 2006). The exploratory factor analysis revealed a two-factor solution of the PTCS accounting for 70.74% of the variance. The convergent validity of the PTCS was

established via its correlational investigation with other psychological measures such as self-esteem and attitudes toward medication (Tsang et al., 2006).

The 18-item Brief Psychiatric Rating Scale (BPRS; Overall and Gorham, 1962) was used to measure psychotic symptoms such as conceptual disorganization, hallucinatory behavior, and unusual thought content of the participants. BPRS is a reliable, valid, and sensitive tool (Ligon and Thyer, 2000) in measuring psychopathology among individuals with schizophrenia (Leucht et al., 2005). This scale is rated on a 6-point Likert scale, with higher summated score representing more severe psychiatric symptoms.

The Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 2000) was used to assess the psychological, social, and occupational functioning of the participants. The single-item GAF is scored from 0 to 100, in which a higher score represents better psychosocial functioning.

The Chinese Self-stigma of Mental Illness Scale (CSSMIS; Fung et al., 2007) contains one subscale (stereotype awareness) to measure perceived stigma, and three subscales (stereotype agreement, self-concurrence, and self-esteem decrement) to measure self-stigma. The three self-stigma subscales are in line with the three-tier mechanism of self-stigmatization (Corrigan et al., 2006). Each subscale contains 13 negative (e.g. persons with mental illness are dangerous) and two positive items (e.g. persons with mental illness are unusually artistic). The items are rated from “(1) strongly disagree” to “(9) strongly agree”, with higher summated score representing higher level of stigmatization. The internal consistency ($\alpha = 0.82-0.90$) and test-retest reliability ($ICC = 0.71-0.81$) were good (Fung et al., 2007).

The 32-item Change Assessment Questionnaire for People with Severe and Persistent Mental Illness (CAQ-SPMI; Hilburger, 1995) is designed to measure the readiness of receiving treatment among the individuals with severe mental illness. This scale comprises subscales of “precontemplation” (e.g., as far as I am concerned, I don't have any mental health problems that need changing), “contemplation” (e.g., it might be worthwhile to change a few things about myself), “action” (e.g., I am doing something to deal with the mental health problems that have been bothering me), and “maintenance” (e.g., I may need a boost right now to help me maintain the changes I have already made), which are rated on a 5-point Likert scale from “strongly agree” to “strongly disagree”. The indices were calculated by adding up the item scores within each subscale. Good internal consistency ($\alpha = 0.79-0.89$) was demonstrated for this scale (Chou et al., 2004).

The three current and past insight items of the Scale to Assess Unawareness of Mental Disorders (SUMD; Amador et al., 1993) were used to assess participants' awareness of mental illness, the achieved effect of medication, and the social consequences of mental disorder. The items are rated on a 5-point Likert Scale from “(1) aware” to “(5) not aware”. Independent item scores were used in this study. Individuals who have better insight toward own mental illness would obtain lower scores on each item. Satisfactory inter-rater intra-class coefficient ($ICC = .67-.89$) was reported (Fung et al., 2008).

The 10 item Chinese General Self-efficacy Scale (CGSS; Chiu and Tsang, 2004) was used to assess the general self-efficacy among individuals with schizophrenia. “It is easy for me to stick to my aims and accomplish my goal” is a sample of the items. Each item is rated from “(1) Not at all true” to “(4) Exactly true”, and higher summated score represents better general self-efficacy among the participants. Good internal consistency ($\alpha = 0.92-0.93$) and test-retest reliability ($ICC = 0.75-0.94$) were demonstrated for the CGSS (Chiu and Tsang, 2004).

The therapist-rated questionnaires (PTCS, BPRS and GAF) were written in English and the Chinese version was not required. In contrast, the CAQ-SPMI was translated into Chinese and validated by Chou et al. (2004), whereas the translation and validation of CSSMIS, SUMD, and CGSS were, respectively, conducted by Chiu and Tsang (2004), Tsang et al. (2006) and Fung et al. (2007). All questionnaires were firstly translated into Chinese by a qualified translator. Then, the Chinese questionnaires were back-translated to English by another independent translator. The discrepancies of the two versions were reconciled by a group of mental health experts. Subsequently, the psychometric prosperities of those questionnaires were established.

2.3. Data collection

The case therapists who helped in data collection were either occupational therapists, social workers, or nurses. All of them had extensive experience in providing psychosocial treatment to the participants. Before data collection, the case therapists received a training session with case illustrations and discussion conducted by the second author. The aim was to ensure the correct completion of therapist-rated questionnaires.

First, the case therapists identified eligible cases from the corresponding psychiatric units. Eligible cases (1) were aged between 18 and 65; (2) obtained a DSM-IV diagnosis of schizophrenia from certified psychiatrists; (3) engaged in the psychosocial treatment for the past 3 months before interview was conducted; (4) were elementarily educated; and (5) did not have developmental disabilities. The participating psychiatric units shortlisted all eligible participants, and selected them via convenience sampling for interview. Second, the case therapists provided the demographic information, and completed the PTCS, BPRS, and GAF after they had obtained individual written consents from participants. The information was gathered from cases therapists via participants' medical records, and their daily clinical observation. Then experienced research assistants from the first author's team completed CSSMIS, CAQ-SPMI, SUMD, and CGSS through the direct interview with

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