



Parsing the relationship of stigma and insight to psychological well-being in psychotic disorders

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ARTICLE INFO

Article history:

Received 15 July 2011

Received in revised form 30 August 2011

Accepted 2 September 2011

Available online 29 September 2011

Keywords:

Stigma

Insight

Psychosis

ABSTRACT

Background: It has been postulated that the effects of the stigma of mental illness on the psychological well-being of patients is mediated through internalization of the stigma. On the other hand, there is reason to suppose that simple awareness of public stigma could also have an impact to the extent that an individual is aware of being ill.

Aim: To investigate whether internalization of the stigma of having a psychotic disorder and an interaction between perceived public stigma and awareness of being ill make independent contributions to the prediction of psychological well-being in patients with psychotic disorder.

Method: 102 patients in an early intervention program for psychoses were assessed for awareness of public stigma, internalization of stigmatizing beliefs, insight and various aspects of psychological well-being including self-esteem, depression, anxiety, anger/hostility and engulfment.

Results: Internalization of stigma was associated with lower levels of psychological well-being. In addition, perception of public stigma also contributed to lower well-being for those individuals with greater awareness of being ill.

Conclusions: While internalization of stigma is an important contribution to psychological well-being in patients with psychosis, awareness of public stigma, even if this is not internalized, also is associated with lower self-esteem, and greater anxiety, anger/hostility, and engulfment in patients with better insight.

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1. Introduction

In recent years there has been increasing interest in the effect of stigma on the psychological well-being of those with psychiatric disorders (Lincoln et al., 2007; Lysaker et al., 2007a; Watson et al., 2007; Williams, 2008). Central to research in this area is the concept of self-stigma (Corrigan et al., 2006; Ritsher and Phelan, 2004; Watson et al., 2007), which refers to the extent to which individuals with a psychiatric disorder have internalized or applied to themselves societal stigmatizing beliefs regarding their illness (Lysaker et al., 2007b; Watson et al., 2007). This concept is usually differentiated from simple awareness of the stigmatizing beliefs and reactions of others. Corrigan and colleagues (Corrigan and Calabrese, 2005; Corrigan et al., 2006), have hypothesized that the acceptance of negative stigmatizing stereotypes as applying to oneself is the primary mediator of any effects of the stigma of mental illness on self-esteem and related indices of psychological well-being.

There is, however, reason to hypothesize that simple awareness of the public stigma associated with a psychiatric illness may have an effect on self-esteem and psychological well-being even if it is not internalized. In particular, it has been postulated that perceived risk of social exclusion by others for any reason has direct implications for self-esteem and associated emotions (Allen and Badcock, 2003; Baumeister and Leary, 1995; Leary, 2004). Such models are consistent with a drive to be positively evaluated by others because of its implications for survival, as well as past findings that self-esteem can be influenced by our awareness of how others view us independently of our own adoption of those views (Crocker and Major, 1989; Shrauger and Schoeneman, 1979).

The possibility that perception of stigmatizing beliefs by others regarding a mental illness and internalization of those beliefs can independently contribute to a patient's psychological well-being could have implications for understanding the relationship between insight and stigma for individuals with psychotic disorders. Two previous reports (Lysaker et al., 2007b; Staring et al., 2009) suggest that the implications of having insight concerning one's psychotic illness for psychological well-being are moderated by stigma. Lysaker et al. (2007b), presented evidence that individuals with schizophrenia spectrum disorders who have insight into their illness and self-stigmatize, have less self-esteem and greater feelings of hopelessness than those who had insight and do not stigmatize, or those who

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have poor insight. Similarly, Staring et al. (2009) found that individuals with insight into schizophrenia and awareness of stigma, had lower self-esteem and greater depression than those with insight and less awareness of stigma or those with poor insight.

What aspects of stigma are likely to moderate the effects of insight on psychological well-being? Lysaker et al. (2007b) used the Internalized Stigma of Mental Illness Scale (Ritscher et al., 2003). This scale reflects several dimensions of stigma experience, but does not provide a clear separation of the awareness of public stigma from accepting those stigmatizing beliefs as applying to oneself. Staring et al. used a measure of perceived devaluation and discrimination, which primarily reflects perceived evaluations by others.

It appears likely that internalizing stigmatizing beliefs will have direct effects on psychological well-being. On the other hand, perception of public stigma could also have an impact on one's psychological well-being to the extent that one accepts that one has an illness and is, therefore, at risk of social rejection by others. These considerations suggest that perception of public stigma will interact with the awareness of illness in predicting indices of psychological well-being. Furthermore, it appears likely that it is awareness of having such an illness as opposed to other aspects of insight, such as need for treatment, which is the primary moderator of the effect of stigma experiences on psychological well-being.

Past studies of the effects of stigma and insight on psychological well-being have focussed primarily on indices of self-esteem or those related to depression. There is also evidence that perceptions of stigma and associated social rejection may relate to anxiety (Birchwood et al., 2006; Leary, 2007), anger or hostility (D'Zurilla et al., 2003; Galambos et al., 2006; Houlihan et al., 1994), and sense of engulfment by one's illness (Estroff, 1989; McCay and Seeman, 1998).

Here we report a cross-sectional study of patients in a first episode program for psychosis that examines the impact of insight and stigma on self-esteem, depression, anxiety, anger/hostility, and engulfment. In particular, our objective is to test the hypothesis that psychological well-being is separately predicted by two aspects of stigma: internalization of negative stereotypes as applied to the self, and an interaction between perceived public stigma and awareness of being ill.

2. Methods

2.1. Participants

Participants were 102 current patients of the Prevention and Early Intervention Program for Psychoses (PEPP) in London, Ontario, Canada. PEPP is designed to treat primarily non-affective, first episode psychotic disorders. There were 72 males and 30 females in the sample with an average age of 26.9 years ($sd=7.4$). Sixty-one participants (59.8%) had a diagnosis of schizophrenia; 13 (12.7%) schizoaffective disorder; 11 (10.8%) psychosis NOS; 8 (7.8%) substance induced psychosis; 5 (4.9%) schizophreniform; and 2 (1.9%) with each of bipolar or delusional disorder. Participants had been receiving treatment for an average of 3.9 years (sd 3.8 years). All participants had the purpose and procedures of the study explained orally and with a written letter of information prior to signing a consent form. All procedures were approved by the University of Western Ontario Ethics Board for Health Services Research.

2.2. Procedures

Self-report measures of insight, stigma related experiences and beliefs, mood states and self-esteem were completed by participants in an initial session. In a second session one to two weeks later, a research associate carried out ratings of anxiety and depression while blind concerning the results of the self-report measures. We separated the two assessment sessions in order to ensure that the observer ratings were completed independently of the self-report measures.

2.3. Measures

2.3.1. Stigma

Aspects of stigma were assessed using a slightly modified form of the Self-Stigma of Mental Illness Scale (SSMIS) (Corrigan et al., 2006; Watson et al., 2007). The SSMIS includes subscales designed to assess perception of the public stereotype of mental illness: personal agreement with the stereotype; internalization of these stereotypes as applying to oneself; and reduction in self-esteem as a result of internalization. For current purposes, we used two subscales designed to assess perception of the public's stigmatizing stereotypes of mental illness and self-concurrence or internalization of those stereotypes as applying to oneself. Items were modified to make specific reference to having a psychotic disorder. The awareness of stereotypes subscale includes items such as: "I think the public believes that most persons with mental illness like psychosis cannot be trusted," and "I think the public believes that most persons with mental illness like psychosis are dangerous." For the concurrence subscale, the items are worded: "Because I have been diagnosed with a mental illness, I cannot be trusted," etc. Responses to each item are made on a 9-point "strongly disagree" to "strongly agree" scale.

2.3.2. Insight

Insight was assessed by the Birchwood Insight Scale (BIS) (Birchwood et al., 1994). The BIS is an 8-item self-report measure. In addition to a total insight score, the BIS yields subscores for awareness of having an illness (e.g., "If someone said I had a nervous or mental illness, they would be right."); attributing symptoms to an illness (e.g., "None of the unusual things I experience are due to an illness."); and perceived need for treatment (e.g., "The doctor is right in prescribing medication for me."). Responses are made on a 3-point "yes", "unsure", "no" scale.

2.3.3. Self-esteem

Self-esteem was measured using the Self-Esteem Rating Scale (SERS) (Lecomte et al., 2006) and the Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965). The SERS is a 20-item self-rating scale that has been successfully validated for use by patients with psychotic disorders. Sample items include: "I feel confident in my ability to deal with other people", and "I feel inferior to other people" (reverse scored). Items are rated on a 7-point "never" to "always" scale.

The RSES is one of the most widely used measures of self-esteem and consists of 10 items including: "I feel that I am a person of worth, at least on an equal plane with others," "I take a positive attitude toward myself," and "I wish I could have more respect for myself" (reverse-scored). Each item was rated on a 4-point "strongly agree" to "strongly disagree" scale.

2.3.4. Self-report mood

Anxiety, depression and anger/hostility were assessed by the Profile of Mood States (POMS) short form (Curran et al., 1995; Shacham, 1983). This scale asks respondents to rate the extent to which they have experienced 37 different feelings or moods over the past month. Responses are made on a 5-point scale from "not at all" to "extremely". Subscale scores can be calculated for six different dimensions of mood; for current purposes we focus on the dimensions of depression, anxiety and anger/hostility. Ratings used in the depression subscale included those related to feeling unhappy, sad, blue, hopeless, discouraged, miserable, worthless and cheerful (reversed scored). Anxiety items included being tense, on edge, uneasy, restless, nervous, anxious; and anger/hostility items reflected feelings of being angry, peeved, grouchy, annoyed, resentful, bitter and furious. The POMS has good psychometric properties and has been widely used for the assessment of mood in clinical populations (Curran et al., 1995; Keilp et al., 2010; Shacham, 1983; Shi et al., 2011).

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