



Behavioral and characterological self-blame in chronic obstructive pulmonary disease

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ABSTRACT

Objective: To assess behavioral and characterological self-blame, identify demographic and relational correlates of self-blame, and determine the association of self-blame with psychological and clinical outcomes of chronic obstructive pulmonary disease (COPD).

Methods: Data were collected via self-report questionnaires completed by 398 individuals with COPD who had at least a 10 pack-year history of smoking. Behavioral and characterological self-blame were measured, and multiple regression was used to identify correlates of both types of self-blame. Multiple regression was also used to determine the association of self-blame with outcomes of COPD.

Results: More than one-third of participants endorsed the maximum possible score on the measure of behavioral self-blame. The perception that family members blamed the individual for having COPD ($p = .001$), tobacco exposure ($p = .005$), and general family functioning ($p = .002$) were associated with behavioral self-blame. Current smoking status ($p = .001$) and perception of blame from family ($p < .001$) were associated with characterological self-blame. While behavioral self-blame was associated with fewer symptoms of depression ($p = .02$), characterological self-blame was associated with more symptoms of depression ($p = .02$).

Conclusions: Individuals with COPD tend to blame themselves for smoking and other behaviors that may have led to their COPD. Smoking-related variables and the perception that family members blamed the individual for having COPD were associated with self-blame. Findings support the importance of distinguishing between behavioral and characterological self-blame in COPD, as behavioral self-blame had a negative association with depression and characterological self-blame had a positive association with depression.

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Introduction

Chronic obstructive pulmonary disease (COPD) is an incurable disease characterized by progressive shortness of breath. In addition to impairment in quality of life, patients with COPD experience psychological and social consequences of COPD that include depression, anxiety, and social isolation [1–3]. Qualitative research indicates that people with COPD consider it to be a self-inflicted health condition and feel shameful about their prior smoking [4,5]. Given that 80–90% of cases of COPD in the US are due to smoking [6,7], self-blame may be a particularly important aspect of living with COPD. It is unclear who is most likely to experience self-blame. Two studies have reported that age is not associated with self-blame [8,9]; however, one study indicates that older individuals are less likely to report self-blame [10]. A study of women with rheumatoid arthritis found that having a critical husband is associated with

increased self-blame [11]. These studies indicate that demographic and relational characteristics may help to identify individuals who are more likely to experience self-blame.

In previous research, self-blame has been conceptualized as a coping mechanism [8,10,12–14] or an attribution [9,15,16] used to manage chronic illness. Results of studies that conceptualize self-blame as a single construct for managing chronic illness suggest that self-blame is maladaptive. For example, two studies have demonstrated a positive association between self-blame and depression [8,12]. Research has also demonstrated an association between self-blame and decreased quality of life in patients with heart failure [8].

Janoff-Bulman has conceptualized self-blame as consisting of two related but distinct types of blame: behavioral self-blame and characterological self-blame [17]. Behavioral self-blame occurs when an undesirable outcome is blamed on specific behaviors or actions. Characterological self-blame occurs when an undesirable outcome is blamed on one's own character or disposition. Janoff-Bulman has hypothesized that characterological self-blame is maladaptive because blame is placed on non-modifiable factors (i.e., one's own character). In contrast, behavioral self-blame is adaptive, as the blame is placed on modifiable factors (i.e., behavior) [17]. Contrary to these hypotheses, both behavioral and characterological self-blame have been associated with poorer psychological adjustment in women with rheumatoid arthritis [11] and

Abbreviation: COPD, chronic obstructive pulmonary disease; HRQL, health-related quality of life; OR, odds ratio.

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breast cancer [9]. Other research indicates that characterological but not behavioral self-blame is related to greater maladjustment [14], and that behavioral self-blame is related to distress only when the individual also experiences characterological self-blame [15].

Although self-blame has been studied in health conditions such as cancer [15], genital herpes [14], rheumatoid arthritis [11], inflammatory bowel disease [16], and irritable bowel syndrome [18], no quantitative research to date has investigated self-blame in COPD. COPD is an ideal illness in which to study self-blame, since the vast majority of cases of COPD in the US are directly linked to a personal health behavior: tobacco smoking. The objectives of the present study were to assess the extent of behavioral and characterological self-blame, identify demographic and relational correlates of self-blame, and determine the association of self-blame with psychological and clinical outcomes of COPD. By measuring both behavioral and characterological self-blame, we were able to test the hypothesis that behavioral self-blame is adaptive while characterological self-blame is maladaptive.

Methods

Sample and procedures

This protocol was approved by the Institutional Review Board at National Jewish Health and the Colorado Multiple Institutional Review Board. Cross-sectional data were collected from individuals with physician-diagnosed COPD by mailing questionnaires to people who had been assessed or treated for COPD at two medical centers in Denver. These two medical centers were chosen to generate a large and diverse sample. One medical center was a tertiary-care respiratory hospital and the other was a university-affiliated public hospital. Questionnaires were mailed to 1040 people and were returned by 542 people, a 52% response rate.

Eleven of the returned questionnaires were excluded from analyses because the respondents indicated that they did not have COPD. These 11 respondents did not agree with their physician's diagnosis and were excluded because many of the items on the questionnaire only pertain to individuals who self-identify as having COPD. To improve our ability to assess the extent to which current or ex-smokers blame themselves for smoking, we limited our sample to individuals with at least a 10 pack-year history of smoking. This resulted in excluding 59 individuals. Listwise deletion was used to handle missing data in the regression analyses, resulting in a final sample of 398.

Measures

Demographic characteristics

Demographic information was collected through a series of self-report items. Participants were asked to indicate their gender, age, race, ethnicity, education, relationship status, and current smoking status. Pack-years, a quantification of lifetime tobacco exposure, were calculated by multiplying the number of packs of cigarettes smoked per day by the number of years the person has smoked.

Relational characteristics

General family functioning was measured by the 12-item General Functioning subscale of the Family Assessment Device [19]. Questions address aspects of family relationships such as the extent to which family members express feelings with each other, feel accepted by each other, and confide in each other. The score of the General Functioning subscale can range from 1 to 4, and high scores are indicative of less healthy family functioning.

Perception of criticism was assessed via the Perceived Criticism Measure (PCM). The PCM is a single item designed to assess the extent to which the respondent views family members as being critical on a scale ranging from 1 (not at all critical) to 10 (very critical) [20].

Perception of blame from family members was assessed by a single item modeled on the PCM measuring the extent to which a person with COPD views family members as blaming: "To what extent do you think your family blames you for having COPD?" Responses range from 1 (not at all) to 10 (completely).

Self-blame

Behavioral self-blame was assessed via two questions adapted from a study of self-blame and adjustment to cancer [15]. These questions address self-blame for smoking and for any other behavior that led to COPD. The specific questions are: 1) How much do you blame yourself for smoking? 2) How much do you blame yourself for any behavior that led to your COPD? Responses for each item range from not at all (coded as 1) to completely (coded as 5). The score for behavioral self-blame can range from 2 to 10, with higher scores indicating more behavioral self-blame.

Characterological self-blame was assessed via the self-blame subscale of the Internal Health Locus of Control scale [21]. This scale uses three questions to assess a general tendency toward self-blame for negative health outcomes. An example item is: Whatever goes wrong with my health is my own fault. The other items ask whether respondents blame themselves when they get sick and whether respondents believe that they get ill when they are not taking care of themselves properly. Each item is scored on a scale from 1 to 5, and the score for characterological self-blame can range from 3 to 15. Higher scores indicate more characterological self-blame.

Psychological outcomes of COPD

Symptoms of depression and anxiety were measured by the Hospital Anxiety and Depression Scale (HADS) [22]. This fourteen item scale contains 7-item subscales for depression and anxiety. The score for each subscale can range from 0 to 21, with higher scores indicating more symptoms of depression and anxiety. The HADS was designed for use with medical patients; as such, items focus on mood disturbance rather than physical symptoms that could be attributed to chronic illness.

Clinical outcomes of COPD

Health-related quality of life (HRQL) was measured by the St. George's Respiratory Questionnaire (SGRQ) [23]. The SGRQ is a 50-item scale designed to measure HRQL in people with airflow limitation. Items are summed and weighted to create a total scale score that can range from 0 to 100, with higher scores on the SGRQ reflecting greater impairment in quality of life.

Breathlessness was measured by the Modified Medical Research Council Scale (MRC) [24], a 5-point grading scale with higher scores indicating more breathlessness. The MRC is predictive of 5-year survival among people with COPD [25].

Analyses

Data were analyzed using PASW Statistics Version 18. Characteristics of the sample were summarized using means and standard deviations for continuous variables and number and percentage of participants for categorical variables. The Pearson correlation was calculated to assess the association between behavioral and characterological self-blame. To identify demographic and relational correlates of self-blame, two multiple regression models were utilized: one for behavioral self-blame and one for characterological self-blame. The same set of independent variables was used for both models, and included the following variables: gender, age, education, relationship status, current smoking status, tobacco exposure, general family functioning, perceived family criticism, and perceived family blame. All of the independent variables were entered simultaneously. To determine the association of self-blame with psychological and clinical outcomes of COPD, four multiple regression models were utilized: one for symptoms of depression, one

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