



When paranoia fails to enhance self-esteem: Explicit and implicit self-esteem and its discrepancy in patients with persecutory delusions compared to depressed and healthy controls

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ABSTRACT

The hypothesis that persecutory delusions function to enhance self-esteem implies that patients will show normal explicit, but low implicit self-esteem. As evidence for this has been inconsistent, our study assessed delusional state, explicit and implicit self-esteem and depression in a large sample ($n = 139$) of schizophrenia patients with acute persecutory delusions ($n = 28$), patients with remitted persecutory delusions ($n = 31$), healthy controls ($n = 59$), and depressed controls ($n = 21$). Patients with delusions and patients with depression both showed decreased levels of explicit, but normal levels of implicit self-esteem when compared to healthy controls. The direct comparison of levels of explicit and implicit self-esteem within each group revealed that healthy controls had higher explicit than implicit self-esteem, while the converse pattern was found for depressed controls. No discrepancy between explicit and implicit self-esteem was found for acute deluded or remitted patients with schizophrenia. Although these findings do not support the hypothesis that delusions serve to enhance self-esteem, they underline the relevance of low self-esteem in patients with persecutory delusions and point to the necessity of enhancing self-esteem in therapy.

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1. Introduction

Low self-esteem is associated with a range of mental disorders and social problems (Mann et al., 2004). During recent years, evidence from clinical (Thewissen et al., 2008) and nonclinical populations (Combs and Penn, 2004) demonstrates that negative self-evaluations are closely linked to paranoia. Thus, self-esteem has been included in the multicausal cognitive model of positive symptoms of psychosis (Garety et al., 2001; Kuipers et al., 2006) that postulates a loss of self-esteem, an external personal attributional style for negative events, impaired theory of mind and deficient reasoning processes to play an important role in the development and maintenance of delusions. Moreover, the model of persecutory delusions (Freeman et al., 2002) postulates negative evaluations of the self, others and the world to influence the formation of persecutory delusions, which then further confirm the negative evaluations and enhance the emotional distress. In support of this, a recent study by Bentall et al. (2009) demonstrated paranoia to be associated with cognitive deficits and a pessimistic thinking style, characterized by low self-esteem, a pessimistic explanatory style and negative emotions.

Nevertheless, the evidence for the first theory put forward by Bentall et al. (1994, 2001) which initiated the abundant research on self-esteem in patients with persecutory delusions has remained equivocal (Garety and Freeman, 1999; Freeman, 2007). Bentall et al. (1994, 2001) argued that persecutory delusions in patients with schizophrenia may serve to enhance their underlying low self-esteem by accusing others for their own failures. The mechanism that triggers this defensive reaction is the activation of a discrepancy between the actual-self (the way I actually am) and the ideal-self (the way I would like to be) by threat related events (Bentall et al., 1994). According to this theory, to reduce the discrepancy, patients with schizophrenia tend to attribute threatening information to another person. Bentall et al. (2001) argued that although the patients use an external personal attributional style for negative events, their negative self-schemas remain latent. Thus “a discrepancy between implicit indices of self-esteem and explicit measures might be thought to be particularly strong evidence for a defensive model” (p. 1164, Bentall et al., 2001). While patients with paranoia are supposed to show normal or even heightened self-esteem in direct or explicit measures, their implicit self-esteem is hypothesized to be low.

Explicit self-esteem is commonly assessed using questionnaires in which the participant is asked to rate self-related statements. Implicit self-esteem can be assessed using memory biases (e.g. the number of remembered positive and negative self-descriptive words) or reaction

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times for associations of self-related words with pleasant and unpleasant words (e.g. Implicit Association Task, IAT, Greenwald et al., 1998; Greenwald and Farnham, 2000).

In contrast to Bentall et al.'s (1994, 2001) hypothesis, patients with paranoia were found to have low rather than normal or high levels of explicit self-esteem compared to healthy controls (Moritz et al., 2006; McKay et al., 2007; Merrin et al., 2007; Vázquez et al., 2008; Combs et al., 2009). Implicit self-esteem was assessed only in few studies and the results are inconsistent. Using the well established IAT (Greenwald et al., 1998; Greenwald and Farnham, 2000), Moritz et al. (2006) and McKay et al. (2007) found patients with paranoia to have low levels of implicit self-esteem, whereas other studies (Bentall and Kaney, 1989; Fear, 1996) that used the Emotional Stroop Test (Williams et al., 1996) did not. Additionally, Vázquez et al. (2008) found low levels of positive implicit self-esteem in the patient sample, who remembered less positive self-descriptive words than controls, whereas no difference was found for negative self-descriptive words.

Both Moritz et al. (2006) and McKay et al. (2007) assessed explicit and implicit self-esteem in patients with delusions. However, Vázquez et al. (2008) extended those results by comparing z-transformed levels of explicit and implicit self-esteem in order to directly assess the hypothesized discrepancy between the two self-esteem measures. No discrepancy was found for acute deluded and remitted patients, but, surprisingly, the healthy and depressed controls revealed the discrepancy: healthy controls showed higher explicit than implicit self-esteem, while depressed controls revealed the converse pattern.

Differences between previous findings in explicit and implicit self-esteem may result from small sample sizes ($n < 17$ for each group in Bentall and Kaney, 1989; Kinderman, 1994; Lyon et al., 1994; Moritz et al., 2006; McKay et al., 2007) or inhomogeneous samples (samples of patients with different psychotic disorders, e.g. McKay et al., 2007). Additionally, as earlier studies (Bentall and Kaney, 1989; Fear, 1996) assessed implicit self-esteem using an uncomputerized measure for reaction times (Emotional Stroop Test, Williams et al., 1996), the reliability for these assessments might be questionable. Finally, although the reliability of the Self-Referent Incidental Recall Task (SRIRT, Dent and Teasdale, 1988), which was used as an implicit measure for self-esteem in the study by Vázquez et al. (2008), has been demonstrated (Cronbach's alpha: $r = 0.80$), its validity is still questionable.

Due to the small studies and the inconsistent results, explicit and implicit self-esteem and their discrepancy will be assessed in a larger and more homogenous sample of paranoid patients in this study. Their levels of self-esteem will be compared to those of healthy and

depressed controls using measures with good psychometric properties. In accordance with the majority of the previous results, we hypothesize that (1) patients with delusions will show low explicit self-esteem when compared to healthy controls. In line with Bentall et al. (1994, 2001), we assume that (2) the patients with delusions will show low implicit self-esteem and (3) reveal lower levels of implicit than explicit self-esteem. No discrepancy between explicit and implicit levels is expected for healthy and depressed individuals. To assess whether levels of self-esteem are linked to the acuteness of symptoms, self-esteem will be assessed in acute deluded and remitted patients separately.

2. Methods

2.1. Participants

The total sample ($n = 139$) consists of an acute deluded group (AD; $n = 28$), a remitted deluded group (RD, $n = 31$), a healthy control group (HC, $n = 59$) and a depressed control group (DC, $n = 21$). Sociodemographic variables of the four groups and statistics for group comparisons are depicted in Table 1.

The acute and remitted deluded patients were diagnosed with schizophrenia according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994) or the International Classification of Mental Disease (ICD-10, Dilling et al., 2000). Diagnoses were based on the Structured Clinical Interview for DSM-IV (SCID, Wittchen et al., 1997) or the International Checklist for ICD-10 (Janca and Hiller, 1996). For all patients, persecutory delusions were the most relevant delusions they were experiencing. Depending on the extent of persecutory delusions (P6 item of the Positive and Negative Syndrome Scale (PANSS), Kay et al., 1987), patients were divided into an acute deluded ($P6 \geq 4$, $n = 28$, AD) and a remitted ($P6 \leq 3$, $n = 31$, RD) group. All deluded patients, except two, were receiving antipsychotic medication at the time of assessment. The mean chlorpromazine equivalent dose was 789.23 (S.D. = 806.13). Patients were recruited in a psychological outpatient department in Marburg/Germany ($n = 34$) and in acute psychiatric inpatient settings ($n = 25$) in Marburg, Haina, Werneck and Marienheide. Inclusion criteria were sufficient German language skills to complete the assessment, age between 16 and 69, diagnoses of schizophrenia and no prevalent diagnosis of dementia, substance abuse or brain organic disorder. The healthy control group (HC, $n = 59$) was recruited via advertisements and selected to match the deluded groups in age, gender and educational status. Individuals with any current diagnosis of mental disorder or substance abuse and with a lifetime diagnosis of schizophrenia were excluded using the short version of the SCID for assessment. The depressed control group (DC, $n = 21$) consists of patients diagnosed with a depressive disorder according to ICD-10 (Dilling et al., 2000). Diagnoses were based on the computerized version of the Composite International Diagnostic Interview (CIDI, World Health Organization, 1990). Patients were recruited in an inpatient setting in Lindow/Germany. The four groups differed in age, with the depressed controls being significantly older than the other three groups (AD, RD, and HC). Thus, we controlled for age in the following analyses. No differences among the groups were found for gender and educational status.

The study was approved by the national ethics committee of the German Society for Psychology. All participants gave written informed consent prior to the assessment. The samples used in this study partly overlap with the samples used in a study by Mehl et al. (2010) who assessed associations between explicit and implicit attributions and self-esteem in 41 patients with delusions and 21 healthy controls.

Table 1
Sociodemographic variables and symptom scores of acute deluded (AD), remitted deluded (RD), healthy (HC), and depressed (DC) participants.

Groups	AD ($n = 28$)	RD ($n = 31$)	HC ($n = 59$)	DC ($n = 21$)	Test-statistics	Post hoc
Mean age in years (S.D.)	34.64 (11.26)	32.00 (9.70)	35.15 (11.63)	46.75 (8.12)	$F = 8.43$; d.f. = 3; 137, $P < 0.001$;	DC > AD, $P = 0.001$; DC > RD, HC, $P < 0.001$
Female (%)	35.7	35.5	33.9	66.7	$\chi^2 = 7.63$; d.f. = 3, $P = 0.054$	
Educational status ^a (S.D.)	2.75 (0.80)	3.13 (0.76)	3.08 (0.82)	2.90 (0.54)	$BF^b = 1.68$; d.f. = 3, 115.04; $P = 1.49$	
PANSS P6 score (S.D.)	4.64 (0.78)	2.32 (0.75)	–	–	$t = 11.64$; d.f. = 57, $P < 0.001$	
PANSS positive score (S.D.)	19.93 (3.79)	13.55 (3.76)	–	–	$t = 6.49$; d.f. = 57, $P < 0.001$	
PANSS negative score (S.D.)	17.46 (4.61)	13.97 (4.29)	–	–	$t = 3.02$; d.f. = 57, $P = 0.004$	
Paranoia Checklist/frequency scale (S.D.)	46.05 (15.84)	29.30 (8.09)	24.91 (10.58)	28.67 (13.62)	$BF^b = 14.73$; d.f. = 3; 66.36, $P < 0.001$	AD > RD, HC, DC (all $P < 0.001$)
BDI total score (S.D.)	17.42 (10.54)	16.45 (9.23)	–	20.57 (10.21)	$F = 1.12$; d.f. = 2, 77, $P = 0.33$	

Note: PANSS = Positive and Negative Syndrome Scale; BDI = Beck Depression Inventory.

^a Educational status: 0 = no school leaving certificate; 1 = elementary school; 2 = secondary school; 3 = high school graduate.

^b BF = Brown-Forsythe correction.

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