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Research paper

Positive beliefs about mental illness: Associations with sex, age, diagnosis, and clinical outcomes

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ABSTRACT

Background: Beliefs about mental illness affect how individuals cope with their symptoms. Positive beliefs about mental illness (PBMI) refer to perceptions of positive attributes individuals may identify in their illness, such as beneficial consequences, enhanced creativity or cognition, or growth through adversity.
Methods: The present study developed and tested a brief measure of PBMI in 332 adults presenting for partial hospitalization with a variety of acute psychiatric conditions.
Results: Results indicated that older individuals and women had lower levels of PBMI than others, while individuals with bipolar disorder had higher levels of PBMI than others. PBMI significantly increased over the course of brief standard treatment. Baseline levels of PBMI, as well as changes in PBMI over the course of treatment, were associated with clinical outcomes including, but not limited to, depression and well-being. A diagnosis of bipolar disorder moderated the relationship between PBMI and only one clinical outcome, emotional lability. Increases in PBMI during treatment were associated with reduced emotional lability only in participants without bipolar disorder.
Limitations: Our findings are limited by the naturalistic study design. In addition, the lack of ethnoracial diversity in our sample limits the generalization of results.
Conclusions: Our results suggest that PBMI are a distinct set of beliefs that meaningfully relate to demographic characteristics, diagnostic characteristics, and clinical outcomes. Future research should examine the mechanisms through which PBMI and outcomes are related, as well as determine whether interventions designed to address PBMI (and perhaps tailored for different diagnostic groups) have clinical utility.

1. Introduction

Many individuals have reported identifying both negative and positive features in their own experiences with mental illness (Lobban et al., 2012; Wood and Tarrier, 2010). Although some preliminary research has investigated such positive features (Galvez et al., 2011), little empirical data to date speak to the existence and nature of *subjective positive beliefs* associated with an individual's disorder(s) or symptoms. Examining these beliefs is especially important given that an individual's understanding of their own psychological difficulties affects how they cope with symptoms by influencing their immediate cognitions and their willingness to seek help (Segal et al., 2005).

Prior research on beliefs held by individuals with mental illness has predominantly focused on *self-stigma* (also known as *internalized stigma*), referring to the subjective perception and awareness of negative stereotypes associated with one's mental illness (e.g., beliefs that individuals who suffer from psychological disorders are dangerous, incompetent, and irresponsible) and the application of these stereotypes to oneself (Boyd et al., 2014a; Corrigan et al., 2006; Rüsch et al., 2005). Of note, not all individuals with mental illness internalize stigma. Rather, some individuals reject negative stereotypes and consequently build empowerment (Corrigan and Watson, 2002), which predicts better outcomes (Link et al., 2001, 1997; Livingston and Boyd, 2010; Lysaker et al., 2007; Ritsher and Phelan, 2004; Schomerus et al., 2009).

Empowering beliefs consist of cognitions that allow individuals to resist and reject stigma (Oyserman and Swim, 2001; Shih,

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2004). Although likely closely related, they still do not quite capture another kind of belief people may have about their disorder (s) or symptoms: positive beliefs about mental illness (PBMI). These refer to perceptions of specific positive qualities, benefits, or advantages individuals associate with their disorder(s) or symptoms. To date, most of the preliminary research suggesting the existence of PBMI has focused on bipolar disorder even though PBMI may also be important in other disorders. Three primary themes have been empirically studied (though others may exist, see Galvez et al., 2011): functional consequences of symptoms, creativity and cognition, and growth through adversity.

1.1. Functional consequences of symptoms

Many theories and treatment approaches conceptualize certain symptoms as coping strategies that provide some short-term positive (i.e., reinforcing) consequences. For example, avoidance due to anxiety may help reduce discomfort in the short-run but may increase it in the long-term (Harvey et al., 2004). Yet, to date, little research has sought to assess the degree to which patients are aware of these positive consequences and how these relate to treatment outcomes.

Existing research on this topic has primarily focused on individuals with bipolar disorder, due to the unique inclusion of positive emotions in this symptom profile. Evidence suggests that individuals with bipolar disorder choose more positive interpretations for hypothetical hypomanic symptoms than nonclinical control groups (Jones et al., 2006; Mansell and Jones, 2006) or individuals with unipolar depression (e.g., thinking that racing thoughts are due to being full of good ideas, rather than having too many demands on one's time) (Alatiq et al., 2010; Jamison et al., 1980). In addition to bipolar disorder, Van Kirk (2014) found that perceiving positive consequences for symptoms of obsessive compulsive disorder predicted lower levels of motivation for treatment.

1.2. Creativity and cognition

Research has documented a higher prevalence of mood disorders in specific creative fields (generally artistic) than in the general population (for reviews see Jamison, 1993; Johnson et al., 2012; Ludwig, 1995). In addition, individuals with bipolar disorder and their relatives appear to engage in creative activities more intensely than others (Kyaga et al., 2011; Richards et al., 1988; Simeonova et al., 2005). The possible mechanisms underlying these findings are numerous and controversial (Forgeard and Elstein, 2014; Kaufman, 2009; Kyaga, 2014; Simonton, 2014a, 2014b). One hypothesis is that specific symptoms may enhance creative cognition and production. For example, milder symptoms of mania/hypomania may increase creativity by fostering persistence, drive, ambition, energy, and rapid thinking (Johnson, 2005; Johnson et al., 2012), and depressive thinking styles may be associated with creative thinking through enhanced self-reflection (Verhaeghen et al., 2005). Another hypothesis is that individuals may use creative activities to grow from challenging experiences, such as experiences with mental illness (Forgeard, 2013; Forgeard et al., 2014). Although these findings have intuitive appeal, null or negative findings also exist (Dietrich, 2014; Ghadirian et al., 2001; for a discussion see Kaufman (2009)). Nonetheless, this area of research suggests that individuals suffering from a variety of psychological disorders (and in particular, bipolar disorder) may hold the belief that their symptoms are linked to creativity.

1.3. Growth through adversity

Individuals may also hold positive beliefs about the value of the challenges brought about by mental illness, even though these challenges cause suffering. Growth through adversity is closely linked to other constructs in the literature such as *posttraumatic growth*, *stress-related growth*, or *benefit-finding* (Jayawickreme and Blackie, 2014; Tedeschi et al., 1998). Such growth is generally defined as the retrospective perceptions of positive psychological changes (e.g., improved personal strength, appreciation for life) resulting from highly challenging life circumstances (Tedeschi and Calhoun, 2004, 1996). Apart from trauma, research is needed to examine the existence and nature of growth through adversity following other stressful life experiences, such as experiencing acute symptoms of psychological disorders. Of note, existing treatment approaches often seek to harness potential growth by helping individuals recognize and build their own strengths and resilience in the face of the adversity brought about by psychopathology (Duckworth et al., 2005; Linley, 2006; Rapp, 1998).

1.4. The present study

Prior research supports the hypotheses that PBMI are a distinct set of beliefs, and that individuals with bipolar disorder may be especially likely to endorse them. PBMI may be adaptive insofar as they may encourage individuals to accept challenging experiences and find meaning in the process of coping with difficulties. PBMI may also be problematic if individuals assign high value to symptoms that are otherwise maladaptive, and are therefore less motivated to address them. Given that hypomania and mania are likely to be perceived as having positive value (Jones et al., 2006), when they are associated with high levels of impairment and lower quality of life (Dean et al., 2004), PBMI in bipolar disorder could therefore sometimes be maladaptive.

To date, few studies have quantitatively investigated (a) the degree to which individuals with a wide range of psychopathology endorse PBMI, (b) the extent to which PBMI are related to demographic and clinical characteristics, and (c) whether PBMI change over the course of treatment. The present study sought to develop a brief measure of PBMI, as well as to examine relationships between PBMI, self-stigma, demographics, diagnoses, and clinical outcomes, in a transdiagnostic sample of individuals enrolled in a partial hospitalization program. The following hypotheses guided this study. We expected that:

H1. PBMI would represent a distinct construct from self-stigma.

H2. At baseline, individuals with bipolar disorder would have higher levels of PBMI than individuals with other disorders. Our investigation of associations between PBMI and demographic variables (age, sex) was exploratory.

H3. At baseline, PBMI would be associated with lower levels of symptom severity and higher levels of psychological well-being. These relationships may be moderated by a diagnosis of bipolar disorder (specifically, individuals with bipolar disorder may present an inverse relationship in which PBMI are associated with worse outcomes).

H4. PBMI would increase over the course of treatment. Although standard treatment may not specifically target PBMI, it often incorporates general interventions such as education, contact, and empowerment that are known to change individuals' perceptions of their illness (Rüsch et al., 2005).

H5. Increases in PBMI would be associated with decreases in symptom severity as well as increases in well-being. Again, these relationships may be moderated by a diagnosis of bipolar disorder (specifically, individuals with bipolar disorder may present an inverse relationship in which increases in PBMI are associated with