



Do mentalization skills affect the perception of stigma in patients with epilepsy?

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ABSTRACT

Purpose: We aimed to study the relationship between the mentalizing ability and stigma in patients with epilepsy.

Methods: Patients with epilepsy were administered the following battery of tests: Mini-International Neuropsychiatric Interview (MINI) form, Reading the Mind in the Eyes Test (Eyes Test), Stigma Scale of Epilepsy (SSE), Internalized Stigma of Mental Illness (ISMI) Scale, Beck Depression Inventory (BDI), and Beck Anxiety Inventory (BAI).

Results: Assessment of an association between the Eyes Test score, ISMI Scale total score, and subscale scores revealed a negative significant correlation of Eyes Test scores with approval of stereotypes, perceived discrimination, stigma resistance, and total score. Eyes Test score and BDI scores appears to be significant predictor of internalized stigma among the clinical variables that were studied. A positive significant correlation was detected between BDI score and alienation, perceived discrimination, and total score.

Conclusion: The presence of a correlation between the mentalization and stigma perception in our study demonstrates that these two concepts are connected and that this connection needs further study. In particular, mentalization-based therapy can have an effect on the reduction of the stigma perceptions and in this way can improve the course of the disease, potentially improving the patients' quality of life.

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1. Introduction

Epilepsy is a common neurological disorder presenting with symptoms such as convulsion and loss of consciousness. Prevalence of this disease is 0.52% in Europe, 0.68% in the US, and 1.5% in developing countries [1]. Epilepsy is a universal condition and does not have any ethnic, national, or geographical boundaries [2]. Epilepsy leads to social and psychological problems such as social isolation, feelings of guilt and shame, low self-esteem, anxiety, and stigma [2,3].

Stigma is a depreciative and destructive attitude underpinning the exclusion, alienation, unrecognition, and rejection of the individual [4], consequently demolishing the dignity, marginalizing and essentially reducing the chances of the inflicted individual to achieve their full potential [5].

Stigma varies among different countries and cultures [6–8]. Different forms of stigma such as perceived (sensed) and imposed stigma might be experienced. In perceived stigma, the patients are embarrassed about epilepsy and are afraid of meeting with other people, thus

avoiding it; on the other hand, in imposed stigma, the patients are afraid of being subject to discrimination, which means that imposed stigma refers to the actual phase of discrimination [7]. The coping behavior of the affected individual results in an internalized stigma. Internalized stigma is felt regardless whether the actual discrimination occurs or not [5].

Stigma might be observed in different aspects. Imposed stigma is the attitude pertaining to the formal and informal discrimination toward people with epilepsy, just because they have epilepsy. When stigma is experienced by someone with epilepsy, it is called perceived stigma. Internalized stigma is experienced when there is a painful, internalized struggle with epilepsy even in the absence of any actual encounter with real stigma [9].

It has been reported that the stigmatizing nature of epilepsy and the related psychological discomfort has a considerable impact on the quality of life of individuals with epilepsy; however, the degree and consequences of the perceived stigma is not equal for all individuals. The factors affecting the development and maintenance of feelings of stigma are not exactly known. Frequency of seizures is regarded as an important factor related to the perceived stigma [10].

Theory of mind or mentalization is described as the ability to think about what goes on in other people's minds, to understand the mental status such as emotion, thought, desire, belief, and knowledge in one's own mind or in other people's minds and to represent those mentally

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[11,12]. It is widely accepted that the theory of mind is not a single-dimensional process and indeed includes cognitive and emotional processes [13]. Theory of mind is studied in two dimensions, affective and cognitive. Affective dimension is being able to make inferences about what an individual thinks or feels by paying attention to their facial gesture, motions, tone of voice, and body language. It is based on observable knowledge. Irony comprehension requires the skill of affective theory of mind. Cognitive aspect of theory of mind involves making inferences considering what an individual had said previously. Understanding whether an individual is lying or joking or noticing a fallacy or predicting one's behavior requires this skill [14–16].

It has been reported that mentalization deficit in epilepsy might be due to the deterioration of the prefrontal, orbitofrontal, mesolimbic, and anterior and posterior temporolateral brain structures that promote the theory of mind [17]. Findings of a meta-analysis study have shown that there are significant mentalization deficits in individuals with focal seizures originating from temporal and frontal lobes, but this was not observed in individuals with focal seizures originating from areas other than temporal and frontal lobes [18]. In mesial temporal lobe epilepsy, mentalization problems were detected [19], and in temporal lobe epilepsy, insufficiency in recognizing negative emotions were detected [20]. Moreover, it is suggested that in epilepsy, the cognitive aspect of mentalization might have been more severely affected than the affective aspect of mentalization [18].

The description of mentalization as the ability to understand ourselves and others' emotions, thoughts, and intents suggests that deficits in this skill can cause stigma, especially internalized stigma. Our hypothesis is that mentalization deficits are related to the perception of stigma and internalized stigma. In light of this view, we aimed to study the relationship between the mentalizing ability and stigma in the patients with epilepsy.

2. Methods

2.1. Sample

The study included patients with epilepsy who were over 18 years of age and agreed to take part in the study. Our sample was drawn from patients of the outpatient epilepsy clinic of Muğla Sıtkı Koçman University Training and Research Hospital. These patients were clinically evaluated by the psychiatrist, and those with mental retardation, psychotic disorder, mood disorder, or attention-deficit disorder that could affect the study results were excluded. For the clinical evaluation of the patients, Mini-International Neuropsychiatric Interview (MINI) was used. Psychotic disorders may affect the mentalizing ability, so MINI was used to make a differential diagnosis of patients with epilepsy. Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Stigma Scale of Epilepsy (SSE), Internalized Stigma of Mental Illness (ISMI) Scale, and Reading the Mind in the Eyes Test (Eyes Test) were performed on the patients. Twenty-nine patients were included in the sample group. Local ethic committee approval was obtained for this study and informed consent form was assigned by all of the participants.

2.2. Statistical analysis

Correlations between ISMI Scale scores and the other parameters, such as the Eyes Test score, BDI, BAI, duration of illness, seizure onset age, sex, education, treatment of Antiepileptic drugs (AEDs), seizure frequency, and types of seizures were calculated using Pearson correlation coefficient. Simple linear regression model was used to relate the ISMI Scale total score and each of the significantly correlated explanatory variables. Multiple linear regression was used to model the relationship between ISMI Scale total score and two or more explanatory variables. A *p*-value of <0.05 was considered statistically significant. All statistical data analyses were performed using SPSS v.22.

2.2.1. Data collection form

It aimed to collect general demographic information from the patients. It was given at the first admission. It contained questions about the age, gender, marital status, level of education, place of residence, level of income, habits, used medications, history of accompanying diseases, disease symptoms, and time of onset and, if there is any, current treatment of the patient.

2.2.2. Mini-International Neuropsychiatric Interview (MINI)

A short structured interview, MINI, which is used to diagnose the main Axis I psychiatric disorders in DSM-IV and ICD-10, has been found to have acceptably high level of reliability and validity scores. It is divided into modules separated with letters, and each one of these modules is compatible with a diagnostic classification. In total, there are sixteen modules. In order to keep the interview as short as possible, the patient must be informed of the fact that the interview contains definite questions on psychological problems that require a yes or no answer. All questions are evaluated. The interview was translated to Turkish by A. Engeler (Turkish Version 5.0.0) [21]. Translators of its previous versions are T. Örnek, A. Keskiner, and I. Vahip [22].

2.2.3. Reading the Mind in the Eyes Test (Eyes Test)

Eyes Test comprises of thirty-six photographs that contain only the eye area of actors and actresses. The participant is asked to identify the mental state of the individual in the photograph by choosing the best of the available four options.

The options do not include the five basic emotions, which are fear, sadness, anger, happiness, and disgust. The test is instead based on complex emotions or intents, and thus, it is accepted as an indicator of the ability of theory of mind rather than emotion recognition.

The validity and reliability study of the test in Turkish was carried out by Yıldırım et al. [23]. In the Turkish version, four items were considered to have low internal consistency and were removed with the approval of the original research team. Thus, the Turkish version of the test comprises of thirty-two items. High scores indicate good mentalizing skills. It has also been determined that the Eyes Test score average for adults in Turkish sample is 21.59.

2.2.4. Stigma Scale of Epilepsy (SSE)

The scale was adapted to Turkish by Nevin Kuloğlu Pazarcı and colleagues in 2016 [24]. It is a self-report scale comprising of ten items. Each item contains five Likert-type questions. The lowest score is 10; the highest score is 49. The higher scores indicate greater stigma. Reliability and validity study showed that its median value is 23.

2.2.5. Internalized Stigma of Mental Illness (ISMI) Scale

ISMI Scale is a self-report scale comprising of twenty-nine items that evaluate internalized stigma. It has five subscales, which are Alienation (six items), Approval of Stereotypes (seven items), Perceived Discrimination (five items), Social Withdrawal (six items), and Stigma Resistance (five items). Each item is in the form of a four-grade Likert-type (from 1 = "absolutely disagree" to 4 = "absolutely agree"). Items of the subscale "Stigma Resistance" are scored in reverse. Total score of the scale varies between 4 and 91. High scores indicate that the internalized stigma of the individual is worse. Turkish reliability and validity study of the scale was performed by Ersoy and Varan et al. [25].

2.2.6. Beck Depression Inventory (BDI)

Beck Depression Inventory is designed to measure the intensity of depression. It could also be used to follow up the changes in depression upon treatment and to describe the disease. It comprises of twenty-one items, and each statement is scored between 0 and 3. The patients are asked to choose the expressions that best describe their current status, and the result is obtained by summing up the scores. Depression intensity is evaluated as minimal for scores in the range of 0–9, mild for scores in the range of 10–16, moderate for the scores in the range of

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