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How stigma impacts on people with psychosis: The mediating effect of self-esteem and hopelessness on subjective recovery and psychotic experiences

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ABSTRACT

This study aimed to examine how stigma impacts on symptomatic and subjective recovery from psychosis, both concurrently and longitudinally. We also aimed to investigate whether self-esteem and hopelessness mediated the observed associations between stigma and outcomes. 80 service-users with psychosis completed symptom (Positive and Negative Syndrome Scale) and subjective recovery measures (Process of Recovery Questionnaire) at baseline and 6-months later, and also completed the King Stigma Scale, the Self-Esteem Rating Scale and the Beck Hopelessness Scale at baseline. In cross sectional regression and multiple mediation analyses of the baseline data, we found that stigma predicted both symptomatic and subjective recovery, and the effects of stigma on these outcomes were mediated by hopelessness and self-esteem. When the follow-up data were examined, stigma at baseline continued to predict recovery judgements and symptoms. However, self-esteem only mediated the effect of stigma on PANSS passive social withdrawal. Self-esteem and hopelessness should be considered in interventions to reduce the effects of stigma. Interventions that address the current and long-term effects of stigma may positively affect outcome for people being treated for psychosis.

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1. Introduction

Stigma is a widely researched concept, with public stigma and self-stigma frequently cited as problems by those experiencing mental health issues (Corrigan et al., 2005). Goffman (1986) described stigma as a negative evaluation of an individual as 'tainted' because of attributes such as mental disorder, disability, or ethnicity. Public stigma is typically described as a process of prejudice, stereotypes and discrimination towards the stigmatised group or individual, and self-stigma is the internalisation of these negative attitudes, beliefs and behaviour. This internalisation is a relatively under-researched topic (Yen et al., 2005; Wu and Tang, 2012) with only a small amount of the stigma research focusing on the experiences of the individual and how they personally respond to stigma (Schulze and Angermeyer, 2003; Bagley and King, 2005). Nevertheless, the internalisation of stigma, the processes and mechanisms which underlie it, and the impact that it has is an

important issue. Early studies found that people with mental health problems expect to experience discrimination and receive ill-treatment from others, have less life satisfaction because of stigma, and feel demoralised and rejected by others (Link, 1987; Link et al., 1989; Mansouri and Dowell, 1989; Herman, 1993). Later work has suggested that self-stigma results in reduced self-esteem, increases depression and anxiety and hinders recovery (Schulze and Angermeyer, 2003; Law and Morrison, 2014).

It has been suggested that people who experience psychosis are one of the most stigmatised minority groups in society (Wood et al., 2014a, 2014b) with The Schizophrenia Commission (2012) recently reporting that 87% of individuals with a schizophrenia diagnosis had experienced public stigma and discrimination. Research has repeatedly shown that the majority of the general public hold negative beliefs about people experiencing psychosis; and particularly those diagnosed with schizophrenia. For example, in a survey of a 1000 French citizens on their attitudes towards people with mental illness, it was found that 69% of individuals would engage in social-distancing from individuals with schizophrenia, compared to 29% for bipolar disorder and 7% with autism ($p < 0.001$) (Durand-Zaleski et al., 2012). The primary reason given for this discrepancy was a belief that individuals with

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schizophrenia are highly dangerous. Other studies not only support this observation that people diagnosed with schizophrenia are considered dangerous, but also that they are considered unpredictable (Crisp et al., 2000; Walker and Read, 2002; Stuart et al., 2012), incompetent, to blame for their illness (Corrigan and Kleinlein, 2005) and unlikely to ever recover (Crisp et al., 2000).

These kinds of stigmatising attitudes create a vicious circle of disability and disadvantage through diminishing quality of life (Stolzman, 1994), preventing help-seeking and engagement with mental health services and treatment (Thornicroft et al., 2007), inhibiting social roles, increasing social exclusion and hindering social integration (Link et al., 1997a, 2001; Thornicroft et al., 2007). Individuals also experience reduced life, work and education opportunities (Thornicroft et al., 2009) leaving people feeling ashamed and unwilling to disclose their illness for fear of the repercussions, and questioning their value as a member of society (Jenkins and Carpenter-Song, 2009). This all has a potential impact on recovery in terms of regaining a sense of quality of life and wellbeing, so that individuals report feeling pessimistic about recovery and lacking hope for the future (González-Torres et al., 2007).

It is evident that the impact of public stigma and self-stigma are far-reaching. However, researchers have so far neglected the possibility that both types of stigma, as well as contributing to poor quality of life and poor adjustment, may have an impact on the course and outcome of psychotic illness (Livingston and Boyd, 2010). This could happen if they impact on psychological mechanisms which in turn affect either symptoms, or subjective recovery or both. Two likely mechanisms which may play this role, which are investigated in the current study, are self-esteem and hopelessness, which have both previously been identified as responses to public stigma (Link et al., 2001; González-Torres et al., 2007) and which are often important elements of psychotic patients' pessimism about their own illness (Pitt et al., 2007).

For self-esteem and hopelessness to play the mediating role hypothesised here, they would have to affect symptoms and subjective recovery, and there is evidence that this may be the case (Lysaker et al., 2007b). Low self-esteem has been identified as a risk factor for psychosis (Janssen et al., 2003) and modern cognitive accounts of positive symptoms, particularly paranoid delusions, emphasise the important role of self-esteem in driving symptoms, especially paranoia (Bentall et al., 2001; Freeman et al., 2002). Indeed, a recent longitudinal study found evidence that negative beliefs about the self and others predicted paranoid symptoms prospectively (Fowler et al., 2013). Another recent study found that self-esteem and negative emotion were major determinants of subjective recovery, and that the impact of positive symptoms on subjective recovery was largely mediated through these variables (Morrison et al., 2013). The role of hopelessness in driving suicidal thinking is well documented (Heilä et al., 1997; King et al., 2001; Nordentoft et al., 2002) and a recent systematic review identified hopelessness as a major barrier to recovery (Soundy et al., 2015). Hence it seems reasonable to hypothesise that one pathway through which stigma might affect both objective and subjective outcomes would be through self-esteem and hopelessness.

The aim of the present study is therefore to test the predictions that: (a) perceptions of stigma will predict both objective and subjective outcome of psychosis; we also attempted to assess whether any such effects are short term (immediate) or long-term (6-months); (b) that observed relationships between perceived stigma and outcome will be mediated by self-esteem and hopelessness.

2. Methods

2.1. Participants and design

Eighty service-users (49 male, 31 female, mean age=39.15, SD=11.56) with experiences of psychosis were recruited from psychiatric services in 5 NHS trusts in the North-West UK. Two had only completed primary education, 34 had completed secondary education, 28 had been in receipt of vocational training and 15 had been educated at university (data missing from one patient). Six patients had never had an inpatient admission, 7 had one admission and the others had multiple admissions (data missing for 10 patients). All met the ICD criteria for a schizophrenia spectrum diagnosis as determined by their responsible clinicians, and their symptoms were confirmed with a researcher-conducted PANSS interview (PANSS; Kay et al., 1987, 1989). 78 were in receipt of antipsychotic medication; 13 were in receipt of psychological therapies and 46 reported ever having received psychological therapy (data missing from 10 patients). All participants had a sufficient level of English literacy to complete the measures and capacity to provide informed consent. The majority were White British (75%). Participants were recruited from early intervention services ($n=12$), community mental health teams ($n=61$), assertive outreach teams ($n=3$) and other mental health services ($n=4$). Data for all measures were collected at baseline, and the outcome measures were administered a second time six months later.

2.2. Measures

All research measures were administered by graduate psychologists who had received specific training in the relevant assessments. For the present analyses we focused on data pertaining to the key concepts of perceived stigma and recovery, with the influence of hopelessness and self-esteem considered as mediators. Other measures which will be reported in later papers are not discussed here.

2.2.1. Independent variables

2.2.1.1. Stigma. The King et al. Stigma Scale (KSS; King et al., 2007) is a 28-item self-report questionnaire measure of perceived stigma with items rated on a scale of 0 (strongly disagree) to 4 (strongly agree). There are three sub-scales: Discrimination (12 items), Disclosure (11 items), and Potential Positive Aspects of mental illness (5 items). King et al. (2007) found all items to have a test-retest reliability kappa coefficient of 0.4 or greater. Cronbach's α for Discrimination was reported to be 0.87, for Disclosure 0.85, and for Positive Aspects 0.64. Alpha coefficients for all scales in the current sample are given in Table 1. It can be seen that, whereas the coefficients for Discrimination and Disclosure in this study were acceptable, that for Positive Aspects was not; therefore this subscale (which was short and, in any case, of less theoretical interest than the others) was not employed in subsequent analyses.

2.2.2. Mediator variables

2.2.2.1. Hopelessness. The Beck Hopelessness Scale (BHS; Beck et al., 1974) is a 20 item self-report measure which measures three aspects of hopelessness: feelings about the future, loss of motivation, and negative expectations. Participants rate each statement as true or false for their attitudes over the last week. The psychometric properties of the BHS have been examined in a number of studies and it has demonstrated good validity and reliability (Young et al., 1993; Dyce, 1996; Nunn et al., 1996).

2.2.2.2. Self-esteem. The Self Esteem Rating Scale—short form (SERS; Lecomte et al., 2006) is a 20-item self-report measure assessing

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