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Insight in paranoia: The role of experiential avoidance and internalized stigma

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ABSTRACT

Evidence suggests that insight in psychosis has been related to treatment adherence, recovery and good prognosis, but also to depression, low self-esteem, and diminished quality of life. Thus, insight might not be advantageous under all circumstances. Internalized-stigma (i.e. self-acceptance of stigmatizing images of illness) and experiential avoidance (i.e. unwillingness to experience negative private events) have been proposed as moderating variables between insight, and psychological health variables and/or distress. We investigated the patterns of association of insight with satisfaction with life, self-esteem, depression, anxiety and psychotic psychopathology as moderated by self-stigmatizing beliefs and experiential avoidance, in a sample of 47 participants with persecutory beliefs and diagnosed with schizophrenia or other psychotic disorder. Moderation analyses confirm the importance of internalized-stigma and experiential avoidance. The presence of insight was associated with more depression when there were high levels of self-stigma. Whereas, the absence of insight was associated with a greater life satisfaction when there were high levels of experiential avoidance. To summarize, our results help understand the complex relationship between insight, psychological health variables and emotional distress, pointing to a differential pattern of moderation for negative and positive outcomes. We discuss the implications of these results for research and treatment of paranoia.

1. Introduction

A frequently proposed key condition for recovery is insight into the illness, defined as awareness of the phenomena and consequences derived from having a mental disorder (David, 1990; Amador, 2000; Lysaker et al., 2009). Lack of insight is one of the major defining characteristics of psychosis and a frequently observed aspect in persons suffering from schizophrenia spectrum disorders (Mintz et al., 2003; Lincoln et al., 2007). Insight is not an all-or nothing condition that someone can either possess or not (David, 1990; Amador et al., 1993; Mintz et al., 2003), but a complex, multi-component phenomenon that may vary in both its degree and the particular areas of personal and social concerns that it extends to (Amador et al., 1991).

Appropriate insight has been connected to treatment adherence, treatment engagement, recovery and good prognosis (Karow et al., 2008), more realistic goals (Lysaker et al., 2001) and to promoting positive social and health outcomes (McEvoy, 1998). In fact, in samples with schizophrenia, lower levels of insight have consistently been related to increased symptomatology and severity (Lincoln et al., 2007), poor psychosocial adjustment (McEvoy, 1998), poor social and vocational functioning (Lincoln et al., 2007), low treatment adherence (Mohamed et al., 2009) and negative prognosis (Barrett et al., 2010).

Nevertheless, evidence is far from being conclusive, suggesting that insight might not be advantageous under all circumstances. Several studies have suggested that higher levels of insight are also associated with increased hopelessness and emotional distress (Kirmayer and Corin, 1998; Karow et al, 2008), depressed mood and lower self-esteem (Martens, 2009; Mohamed et al., 2009; Valiente et al., 2011a), lower subjective quality of life (Karow and Pajonk, 2006; Roseman et al., 2008), higher suicide risk (Hasson-Ohayon et al., 2006), lower physical health and vitality (Karow et al., 2007) as well as lower vocational status and less economic satisfaction (Hasson-Ohayon et al., 2006). Reviewing previous research on recovery, Andresen et al. (2003) have concluded that the elements of recovery from psychosis are a reflection of the core dimensions of psychological well-being as proposed by Ryff and Keyes (1995). Therefore variables such as hope, purpose in life and subjective well-being are very relevant elements in the process of recovery (Onken et al., 2007).

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In conclusion, leaving aside methodological differences between studies, these conflicting findings might be understood bearing in mind additional underlying psychological processes, in particular intrapersonal features that could be moderating the relationship between insight and clinical outcome. In fact, it has been found that insight is associated with less subjective well-being only when it co-occurs with self-stigmatizing beliefs (Lysaker et al., 2007a; Staring et al., 2009). Internalized stigma (IS) refers to the devaluation, shame, secrecy, and withdrawal triggered by applying negative stereotypes to oneself (Corrigan, 1998). IS has been proposed to moderate the associations between insight and depression, low quality of life, and negative self-esteem in persons with schizophrenia (Lysaker et al., 2007a), revealing that patients with high insight and less perceived stigmatization had more positive outcomes and showed the least impaired social functioning (Lysaker et al., 2007a; Staring et al., 2009). Furthermore, other studies have shown that the association between insight and demoralization was stronger as IS increased (Cavelti et al., 2012). Consequently, insight and IS seem to jeopardize the development of positive self-expectancies of competence and success (Mak and Wu, 2006; Lysaker et al., 2009), leading to low self-esteem, hopelessness and lowered quality of life.

Experiential avoidance (EA), a generalized psychological vulnerability construct, has also been identified as a moderating variable between insight and well-being (Valiente et al., 2011a). EA refers to an individual's tendency to suppress or change the form and frequency of undesirable private events such as emotions, thoughts, behaviors or bodily sensations, in order to cope with and regulate arising negative emotions (Hayes et al., 1996). EA has been associated with the development and persistence of psychological problems in general (Hayes et al., 2004), and seems to be implicated in paranoia as well (Udachina et al., 2009). In fact, active avoiding and suppressing represent a frequently used coping strategy in psychotic patients (Shergill et al., 1998) and paranoid patients devote a great deal of effort to avoid negative implications and to maintain a positive self-presentation (Valiente et al., 2011b). Paradoxically, subduing unwanted thoughts and emotions has proven to actually intensify intrusive thoughts, emotional distress, autonomic arousal and auditory hallucinations (Salkovskis and Campbell, 1994).

In the current study, a single symptom approach, focusing on persecutory beliefs rather than psychotic symptoms in general, was used to ensure parsimony. In addition, persecutory delusions seemed to be an appropriate target given that they are a very common symptom and a key clinical manifestation in the schizophrenic spectrum disorders.

The aim of the study was to investigate the relationship of insight with satisfaction with life, self-esteem, depression, anxiety and psychotic psychopathology, assuming that both IS and EA may be moderating these relationships. According to previous research, in our first hypothesis we predicted that lack of insight would be positively related to the severity of positive psychotic and anxiety symptoms, satisfaction with life and self-esteem, and negatively related to depression. Since research provides conflicting evidence for the functional consequences of insight into psychosis, in our second hypothesis, we predicted that the relationships between insight and mental health outcomes in paranoia would be moderated by the extent of IS. We expected to find poorer mental health outcomes when participants showed high levels of insight and high levels of IS. In our third hypothesis, we also predicted that these relationships would be moderated by the extent of EA. We expected to find better outcomes when participants showed low levels of insight and high EA, since low levels of insight together with a tendency to suppress undesirable private events, might result in a positive self-serving presentation of oneself.

2. Method

2.1. Participants

Participants were a convenience sample of inpatients of psychiatric units in two university hospitals. All participants were currently suffering from persecutory beliefs at the time of the study, as assessed by the *Present State Examination* (PSE-10, section 19, WHO, 1992) with a score of 1, 2 or 3 on any the persecutory ideation items (i.e. indicating presence of the symptom; transient, in multiple occasions or constant, respectively). Participants who showed signs of severe cognitive impairment and/or admitted active substance abuse during the clinical interview were excluded. All inpatients meeting the criteria were approached, and 9 out of 60 (15%) refused to participate. The remaining 51 participants volunteered to participate in the study after reading and signing a consent form. However, 4 of 51 (7.8%) were not included in the sample because they did not complete the protocol. The remaining 47 participants (27 men) included in the study met the DSM-IV-TR (APA, 2000) criteria for the following diagnostic categories: paranoid schizophrenia (n = 12), schizophreniform disorder (n = 5), schizoaffective disorder (n = 4), delusional disorder (n = 8), brief psychotic disorder (n = 13), and no specific psychotic disorder (n = 5). All patients received psychiatric treatment at the time of the study. The mean age of the entire group was 31 years (SD = 8.4). The mean age of illness onset was 27.8 years (SD = 6.9). Demographic features of the sample are presented in Table 1.

2.2. Psychiatric and psychological assessments

All clinical participants were evaluated during a psychiatric hospitalization over a two-year period (2011–2012) using the following measures.

2.2.1. Schizophrenia symptoms

The *Positive and Negative Syndrome Scale* (PANSS; Kay et al., 1987) is a widely used scale to evaluate schizophrenia symptoms' severity. It has 30 items with a 7-point rating scale (1–7) and it consists of three subscales: positive symptoms (PANSS-P), negative symptoms (PANSS-N) and general psychopathology (PANSS-PG). The PANSS scales have shown good inter-rater reliability (Peralta and Cuesta, 1994).

Table 1
Demographic and clinical characteristics of the sample.

Characteristic	Total sample (n = 47)
Sex:	
Women, n (%)	20 (42.6)
Age, mean (SD)	31 (8.4)
Marital status, n (%):	
Married	11 (23.4)
Single	31 (66)
Other	5 (10.6)
Education, n (%):	
Primary School	24 (51.1)
Secondary School	16 (34)
University	6 (12.8)
Other	1 (2.1)
Employment, n (%):	
Student	5 (10.9)
Never employed	10 (21.7)
Unemployed for >1 year	6 (13.3%)
Unemployed for <1 year	6 (13)
Employed	19 (41.3)
Age at first diagnosis, mean (SD)	27.8 (6.9)
Number of psychiatric hospitalizations across the life-span	1.56 (1.16)
Number of psychiatric hospitalizations during the preceding year	1.03 (0.28)