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Identity and Cause of Problems: The Perceptions of Patients with a Diagnosis of Schizophrenia

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Abstract. This study explored the beliefs held by 17 individuals with a diagnosis of schizophrenia on the identity and cause of their problems using a semi-structured interview. Just over half of the sample considered their main difficulty to be something other than a psychiatric or psychological problem. Nevertheless, all participants reported having at least one problem, and a range of views concerning the causes of these problems were elicited, with an average of five causal factors endorsed. This suggests that traditional insight scales fail to capture the complex subjective models of understanding held by individuals with a diagnosis of schizophrenia.

Keywords: Schizophrenia, psychosis, insight.

Introduction

Many individuals with a diagnosis of schizophrenia disagree with professionals involved in their care about whether they are mentally ill, whether their unusual experiences are abnormal and whether their problems need treatment. Such individuals are traditionally considered to

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"lack insight". However, such a conceptualization of insight may be limited as it imposes a medical model view of the individual's problems and assumes that there is a "right way" and a "wrong way" to view mental illness (Beck-Sander, 1998). Examining people's subjective understanding of their problems may offer the potential to extend our understanding of the construct of insight.

There is a dearth of published literature examining beliefs held by people with a diagnosis of schizophrenia about the identity of their problems. Studies in this area have more often focused on individuals' attributions of the cause of their illness, and have taken the identity of that illness for granted. Although Lobban, Barrowclough and Jones (2004) found that the majority of their participants attributed their psychotic experiences to a mental health problem when provided with a dichotomous choice in a questionnaire, Moodley and Perkins (1991) found that, using an open-ended interview, over half of their sample denied having a mental health problem. However, 40% of this group did acknowledge having a physical or a social problem.

There is further evidence that individuals with psychosis hold multi-factorial causal theories about their problems, as opposed to the single-factor "illness" cause espoused by the traditional medical model. For example, Angermeyer and Klusmann (1988) showed that recent psychosocial factors (e.g. stressful life events) were the most often cited causal factors, followed (in descending frequency) by personality factors, family factors, biological factors and finally "esoteric" factors (e.g. punishment by God).

The present study explored the beliefs held by individuals with a diagnosis of schizophrenia on the identity and cause of their problems using a semi-structured interview.

Method

Participants

The sample consisted of 11 male and 6 female individuals who met the ICD-10 criteria for schizophrenia, spoke fluent English and had no organic brain damage. The mean age of participants was 34 years (range 20 to 64) and the mean age at onset of illness was 24 years (range 10 to 32). Past psychiatric history was mixed, with the number of admissions to hospital ranging from 0 to 12 (with a mean of 3.8). The mean current dosage of antipsychotic medication was 148 Chlorpromazine equivalent milligrams per day. All participants provided written informed consent.

Measures

The main measurement instrument was a semi-structured interview designed by the authors for the purpose of this study, based on the cognitive dimensions of "identity of illness" and "perceived cause" from Leventhal's Illness Cognition Model (Leventhal, Nerenz and Steel, 1984) (see Appendix 1 in the Extended Report). Beliefs about the nature of individuals' problems were elicited through open ended questions, while level of agreement (on a 7 point scale) with a pre-prepared list of causes was used to evaluate beliefs about the cause of problems.

Table 1. Identity of problems (grouped by content analysis)

Problem type	Examples	Mentioned	Main problem
Psychiatric or psychological	"Hearing voices" "Paranoia"	12 (70.6%)	7 (42.2%)
Physical	"Anaemia" "Constipation"	5 (29.4%)	5 (29.4%)
Practical/social	"Money" "No bus pass"	3 (17.6%)	1 (5.9%)
Relationships with others	"No friends" "Loneliness"	6 (35.3%)	3 (17.6%)
Personal attribute/characteristic	"Low confidence" "Impulsivity"	3 (17.6%)	1 (5.9%)

Table 2. Endorsement of causes of problems (7 point scale, higher score indicates greater endorsement)

Cause	Mean	*SD*
"Out of the ordinary factors" (psychotic phenomena)	4.24	2.61
Nerves	4.18	2.38
Brain problem	4.00	2.40
Life events	3.94	2.38
Practical problems	3.88	2.23
Childhood experience	3.82	2.40
Personal factors	3.71	1.90
Relationship difficulties	3.35	2.15
Physical factors	3.06	2.14
Hormonal factors	2.77	2.14
Genetic factors	2.18	1.67
Deserving of problems	1.47	1.07

Results

Identity of problems

Content analysis was used to categorize responses to open-ended questions concerning the perceived identity of participants' problems. Statements were re-categorized by a blind rater to assess reliability, yielding a mean percentage agreement of 97.7%. Table 1 summarizes the beliefs that individuals held about the nature of their problems.

Cause of problems

Participants' level of agreement with the pre-prepared list of 12 causes for their problems is summarized in Table 2. On average, participants rated five (range 0 to 9) of the causal factors presented as being influential in the genesis of their problems to at least a moderate degree (a score of 4 on the 7 point scale).

Discussion

Participants held a variety of views concerning the nature of the problems in their lives. All participants reported having problems, with psychiatric or psychological problems being the

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most frequently mentioned. Nevertheless, the majority (57.8%) considered their main difficulty to be something other than a psychiatric or psychological problem. The other types of problems reported included, in descending order of frequency, physical problems, relationships with others, practical/social problems and personal attributes. These results suggest that individuals who "lack insight" according to traditional criteria nonetheless recognize that they do have problems, albeit of a different kind. Insight is traditionally framed within the medical model view of schizophrenia, which dictates that anomalous experiences and beliefs, as well as a variety of "negative symptoms", should be perceived as abnormal and be the result of a disease process. Traditional insight scales may therefore fail to capture all the relevant information about whether individuals consider that there is "something wrong".

Academics and clinicians endorse a range of inconclusive causal theories to explain the construct of schizophrenia. The participants in this study also endorsed a range of causal theories, on average five, to at least a moderate degree. While "out of the ordinary" explanations (psychotic phenomena) received the highest endorsement, other causes that received high ratings included "nerves", life events, practical problems, childhood experiences, personal factors and relationship difficulties. However, traditional insight scales do not mirror this diversity of possible causes. From a clinical perspective, awarding greater importance to the ways that individuals formulate their own problems and experiences is becoming increasingly recognized as essential to collaboratively based treatment interventions (Fowler, Garety and Kuipers, 1998).

This study shares a common limitation with all studies investigating the issues surrounding insight in schizophrenia, namely there is likely to be a degree of sampling bias. Non-English speakers were also excluded from this study, and therefore the results may not be representative of the beliefs of all individuals with schizophrenia, which are likely to have some cultural influences.

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