

Poor insight in schizophrenia: links between different forms of metacognition with awareness of symptoms, treatment need, and consequences of illness

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Abstract

Objective: Many persons with schizophrenia experience poor insight or reflexive unawareness of the symptoms and consequences of their illness and, as a result, are at risk for treatment nonadherence and a range of negative outcomes. One recent theory regarding the origins of poor insight in schizophrenia has suggested that it may result, in part, from deficits in metacognitive capacity, or the ability to think about thinking, both one's own and the thinking of others.

Methods: Participants were 65 adults with a schizophrenia spectrum disorder in a postacute phase of illness living in the community. For all participants, we obtained measures of three domains of metacognition, including self-reflectivity, mastery, and perspective taking, using the Metacognitive Assessment Scale and the hinting test and three domains of insight, which were awareness of symptoms, treatment need, and consequences of illness, using the Scale to Assess Unawareness of Mental Disorder. Measures of neurocognition were also collected for potential use as covariates.

Results: Univariate correlations followed by stepwise multiple regressions, which controlled for neurocognition, indicated that self-reflectivity was significantly linked with awareness of symptoms, mastery with treatment need, and mastery and perspective taking were linked with awareness of consequences of illness.

Conclusions: Results suggest that metacognition may be linked to insight in persons with schizophrenia independent of concurrent impairments in neurocognition.

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1. Introduction

Research has suggested that relative to persons with other mental illnesses, many people with schizophrenia spectrum disorders are unaware of their illness [1,2]. Importantly, this phenomenon, which we will refer to as poor insight, may reflect a lack of awareness of a range of things and does not merely suggest ignorance of a holistic

“truth.” Poor insight may involve varying degrees of awareness of different facets of illness, including awareness of specific symptoms, treatment need, or the psychosocial consequences of the illness. As revealed in clinical reports and personal accounts (eg, Ref [3]), some persons, for instance, might deny the need for medication despite a recent hospitalization that occurred after refusing medication. Someone else with poor insight might be fully adherent with treatment yet believe that the hallucinations that he/she experiences have a supernatural origin or see no reason to think anything is wrong despite decades of unemployment and social isolation.

Poor insight in schizophrenia presents practitioners, patients, their friends, and families with a number of

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challenges. For one, if the illness is denied by the person with schizophrenia, it is difficult to see how offers of help could be responded to positively and accepted by the potential patient. Indeed, poor insight has been linked to more negative attitudes toward medication, longer episodes of antipsychotic nonadherence, more frequent hospitalizations [4–7], greater levels of positive and negative symptoms [8,9], and poor psychosocial function [10,11]. In addition, poor insight is not a matter of simply not being able to understand things globally. Persons with poor insight may give valid reports of their psychological [12] and physical health [13] and recognize the symptoms of mental illness when they are being experienced or described by others [14]. When helped to think about how others may think about their lives, they can successfully adopt others' views of their symptoms [15].

Spurred on by these challenges and paradoxes, efforts have intensified to evolve a model of the roots and nature of poor insight in schizophrenia. In a recent summary, Osatuke et al [16] have detailed several models of the etiology of poor insight, including ones framing poor insight as a symptom of cognitive dysfunction (eg, conceptual disorganization, neurocognitive impairment, or neuroanatomic deficit) or as an attempt to avoid or ward off negative connotations of the illness (eg, stigmatizing stereotypes). Research on these models though has been equivocal. Whereas some studies have linked poor insight with poorer performance on neurocognitive assessments, particularly those linked to the prefrontal cortex [17–19] and to decreases in grey matter volume [20], others have failed to find associations between insight and indices of brain function [16]. Supporting the idea that poor insight may be a way to cope, other studies have found that developing insight may lead to depression [21], hopelessness, lower self-esteem, poorer quality of life [22,23], and, possibly, suicidal ideation [24].

One newer model of insight that may help resolve some of these paradoxes suggests that different kinds of deficits in metacognition, or the ability to think about thinking, may play a unique and possibly moderating role in the development of poor insight. Conceptually, metacognition is a phenomenon related to but not synonymous with neurocognition (eg, to have a poor memory is not the same thing as to be aware of one's memory deficits or to know under what circumstances one learns more efficiently). Metacognition refers to a range of semi-independent functions that allow human beings to think about their own thoughts and feelings and the thoughts and feelings of others and to use their ideas about mental states to respond to distress and the challenges of social life [25]. To acknowledge the point of view of the other and to reflect upon one's own experiences are closely related. Both presuppose the capacity to establish a dialogue, either with oneself or with another person, and to take a reflexive stance over one's own thoughts and feelings and the thoughts of the others. Reflexivity is the process whereby one treats a part of one's mental life as an object or as if it were external. This

partial externalization of part of the self allows for the possibility to inspect, judge, question, and narrate one's thoughts and feelings. The capacity to adopt a reflexive stance over one's own thoughts and feelings via a dialogue with oneself or with another person reinforces one's subjective sense of being a self and allows for becoming aware that some of one's thoughts and feelings are symptoms of an illness [26–28].

Different aspects of metacognition may well be expected to be closely related to different facets of insight, when one considers insight as a complex, personal, and narrated account of life events and not the simple denial vs acceptance of a label such as “schizophrenia” [29]. If insight is not defined as merely possessing a piece of knowledge, but instead is conceptualized as a self-representation that might change according to what the person is asked to consider as illness within a specific interpersonal context, then a range of metacognitive capacities are likely to be required beyond the effects of neurocognitive compromise or stigma [30]. For instance, the capacities to recognize oneself as an active agent in the world would seem to be necessary to see one's social isolation as a response to pain or suffering (eg, “I have avoided others as a way to minimize distress”). Similarly, the ability to appreciate the unique perspective of other persons might enable some to find words to describe one's own personal dilemmas associated with mental illness. In parallel, a lack of reflexive awareness of one's own thoughts, feelings, and coping strategies may leave persons less able to form a stable idea of themselves as struggling with internal difficulties and perhaps inclined to see external forces as the cause of symptoms or distress. In support of this possibility are studies that have found that assessments of Theory of Mind and self-reflectivity are correlated with measures of general insight [31–34].

A better understanding of whether different aspects of metacognition are linked to insight may help practitioners form a richer idea of why some persons with schizophrenia deny illness and decline treatment and to appreciate some of the barriers that patients without insight face. This knowledge may help practitioners form an alliance with patients with poor insight and assist them to make sense of their condition in a way in which they can make more adaptive decisions over time.

To explore this issue, the current study sought to explore how 3 different aspects of metacognition—awareness of one's own thoughts and feelings, coping with psychological challenges on the basis of awareness of mental states, and awareness of the perspective of others—and 5 measures of neurocognition were related to 3 different aspects of insight: awareness of symptoms, treatment need, and consequences of illness. In particular, we had 2 primary and 1 secondary group of hypotheses. First, we predicted that greater levels of metacognition would be linked with better insight. Second, we predicted that any links found between insight and metacognition would persist when assessments of neurocognition were controlled for statistically. As noted

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