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# Predictors of subjective well-being in patients with paranoid symptoms: Is insight necessarily advantageous?

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ABSTRACT

In schizophrenia, poor insight has been associated with negative outcome. In fact, some studies have found insight to be associated with greater treatment adherence and lower levels of symptomatology, as well as better psychosocial functioning. However, others have found that insight into illness is associated with an increase in depression, low self-esteem, and possibly higher risk of suicide. We investigated the relationship between insight and well-being in a sample of 40 people presenting paranoid symptoms and diagnosed with schizophrenia or other psychotic disorder. Independent-samples t-tests revealed that compared to a paranoid group with high insight, paranoid participants with low insight had more self-acceptance, higher sense of autonomy and personal growth, and greater orientation towards gratification. Moderation analyses showed that when experiential avoidance was high, insight into paranoia had a detrimental effect on self-acceptance. Overall, our results support the need to explore which psychological variables moderate insight in patients with persecutory beliefs. We discuss the implications of these results for the research of paranoia.


## 1. Introduction

People diagnosed with schizophrenia spectrum disorders who appear to be unaware of their condition are considered to lack insight into their illness (David, 1991; Amador, 2000) which is considered a defining characteristic of psychosis. The presence of insight is associated with enhanced mental health for developing realistic goals (Lysaker et al., 2001) and for promoting positive social and health outcomes (McEvoy, 1998), while lack of insight has been linked to poor therapeutic relationships (Amador et al., 1993), poor adherence to treatment (McEvoy et al., 1989) and less willingness to take prescribed medication (McEvoy et al., 1981).

Evidence suggests that insight is not advantageous under all circumstances. Studies have reported contradictory findings about the effect of patient insight into psychosis on its clinical presentation and treatment. Some have underscored that insight in patients with schizophrenia is associated with fewer symptoms and better compliance with antipsychotic medication (Lysaker et al., 1998; Mohamed et al., 2009). Others, however, have shown that rejection of a stigmatizing mental health label has some benefits (Schwartz, 2001). In fact, Kirmayer and Corin (1998) argued that an individual's insight into psychosis can lower self-esteem and increase despair, helplessness and hopelessness. Moreover, recent studies have reported that greater insight is significantly associated with an increase in depression, low self-esteem and possibly higher risk of suicide (Mohamed et al., 2009).

The last decade has seen renewed research interest into the effects of insight on patient well-being and quality of life (QoL), but the data are not conclusive. In a sample of people with schizophrenia and schizoaffective disorders, Roseman et al. (2008) found that lack of insight predicted poor subjective QoL and directly influenced capacity to function. Similarly, Doyle et al. (1999) found significant positive correlations between insight into schizophrenia and subjective and objective QoL. However, Aghababian et al. (2003) found that schizophrenic patients with high insight evaluated their life more negatively and had lower self-esteem than those with low insight. Indeed, other investigations have found that insight is related to poor psychological adjustment (Amador et al., 1996) low emotional well-being (Hasson-Ohayon et al., 2006), and lower QoL in the physical domain (Yen et al., 2008). Likewise, Karow et al. (2008) found that patients in an acute phase of schizophrenia with more insight were better at recognizing the weaknesses associated with their illness, which worsened their QoL. Hasson-Ohayon et al. (2006) found that subjects with psychotic disorders who had more insight gave more negative assessments of their subjective well-being, job status and economic situation.

These inconsistent findings draw attention to the need to search for factors that may moderate the relationship between insight and well-being. Hope and stigma have been identified as key moderating variables. For instance, Hasson-Ohayon et al. (2009) have found that hope increases the strength of association between insight and positive QoL. Lysaker et al. (2005) found that patients with high

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insight and high hope had more capacity to cope than those with high insight and low hope. Moreover, Lysaker et al. (2007) found a positive association between insight and hope, but only in those patients with low negative stigma. Thus, stigma has been proposed to moderate the associations between insight and depression, low QoL, and negative self-esteem. In other words, patients with good insight and less perceived stigmatization were the most successful across various outcome parameters and they showed the least impaired social functioning (Lysaker et al., 2007; Staring et al., 2009).

Experiential avoidance (EA), as a mechanism to avoid negative self-implications, is another potential moderator between insight and well-being. Individuals who exhibit EA are intolerant of negative mental experiences (e.g., bodily sensations, thoughts and emotions) and they attempt to eliminate them. EA has been associated with the development and persistence of psychological problems and has been correlated with different types of psychopathology (Hayes et al., 2004). In fact, preliminary evidence has suggested that EA may be implicated in paranoia (Udachina et al., 2009). Patients with paranoid symptoms devote a great deal of effort to avoiding negative implications and to maintaining a positive self-presentation. Indeed, a robust finding in paranoia research is a tendency for patients with persecutory delusions to attribute negative events to causes external to the self (Kinderman and Bentall, 1997) that can be linked to dysfunctional strategies of self-esteem regulation observed in these patients (Thewissen et al., 2008).

The new concept of enjoyment orientation can feed into well-being. How well an individual anticipates enjoying an action helps predict the likelihood that he or she will engage in that action (Freitas et al., 2001). The inability to experience pleasure, anhedonia, has been considered a dispositional feature essential in the development of schizophrenia (Meehl, 1987) and its negative outcomes (Fenton and McGlashan, 1994). Enjoyment orientation is likely to be linked to deficits in anticipatory pleasure that have been found in schizophrenia (Gard, et al., 2007), though it may not necessarily be linked to deficits in consummatory pleasure.

### 1.1. Study aims

The primary goal of this study was to examine the relationship between well-being and insight into paranoia. We specifically formulated two hypotheses. First, in line with findings reported by Karow et al. (2008) and Hasson-Ohayon et al. (2006), we expected patients without insight would be less entrapped by their illness, and thus we hypothesized they would have more subjective well-being and more enjoyment orientation than those with insight. Our second hypothesis was that EA would moderate the relationship between insight and well-being: patients with a strong tendency to avoid negative self-experiences would experience more subjective well-being when insight is low than when insight is high. Patients without EA would report similar levels of well-being regardless of whether insight is low or high.

## 2. Methods

### 2.1. Participants

Participants were adult inpatients of an 80-bed psychiatric unit in a university hospital. Patients were recruited based on hospital records, and DSM-IV diagnoses (APA, 1994) were confirmed by trained clinicians based on a clinical structured interview (MINIPLUS, Sheehan and Lecrubier, 2002). All participants were suffering persecutory beliefs at the time of the study, as assessed by the Present State Examination (PSE-10, WHO, 1992). Participants with delusions of guilt were excluded, because these contents are usually associated with major depressive disorders. Also excluded from the study were participants with severe cognitive impairment and active substance abuse. All inpatients meeting criteria were approached, and 8 out of 48 (17%) refused to participate. The remaining 40 (21 men) volunteered to collaborate in the study after reading and signing a consent form.

Participants included in the study met the criteria for the following diagnostic categories: schizophrenia paranoid type ($n=18$), schizophreniform disorder ($n=7$), schizoaffective disorder ($n=4$), delusional disorder ($n=8$), brief psychotic disorder ($n=2$), and psychotic disorder not otherwise specified ($n=1$). All were on doses of atypical antipsychotic medication (injectable medication only, $n=1$; oral medication only, $n=31$; and injectable plus oral, $n=8$).

We used the Positive and Negative Syndrome Scale (PANSS) *insight and judgment item*, which provides a rating of global lack of awareness of symptoms, treatment need, and consequences of illness, to divide the sample in two groups: a *high-insight* group ($n=19$) with scores less than or equal to 3 and a *low-insight* group ($n=21$) with scores higher than 3. A score of 3 was chosen as the cut-off value because it produced groups of similar size.

### 2.2. Materials

All clinical participants were evaluated during hospitalization using the following measures (see Table S1 for internal consistency data, Supplementary Material).

#### 2.2.1. Psychiatric assessment

*2.2.1.1. The Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987).* The PANSS is a 30-item, 7-point rating scale (1–7). For the purposes of this study, we used the following three sub-scales: *positive symptoms* (PANSS-P), *negative symptoms* (PANSS-N) and *general psychopathology* (PANSS-PG). Inter-rater reliability for this study was found to be high: the intra-class correlation for three blind raters was 0.85 for the individual PANSS item *Lack of Insight and Judgement*, as well as for the average PANSS score over all items.

*2.2.1.2. Beck Depression Inventory II (BDI-II; Beck et al., 1988).* This is a 21-item self-report questionnaire to assess the severity of cognitive, affective and somatic symptoms of depression.

#### 2.2.2. Well-being and experiential measures

*2.2.2.1. Scales of Psychological Well-Being (SPWB; Ryff and Keyes, 1995).* This scale was constructed based on a model of multidimensional psychological well-being and has 54 items and 6 sub-scales (Autonomy, Positive relations with other, Self-acceptance, Environmental mastery, Purpose in life and Personal growth). Subjects are asked to indicate their beliefs on a 6-point Likert scale ranging from 1 ("strongly disagree") to 6 ("strongly agree").

*2.2.2.2. Enjoyment Orientation Scale (EOS; Hervás and Vázquez, 2006).* The EOS is a new tool related to the behavioral activation system that is believed to regulate appetitive motives. The EOS assesses the extent to which participants try to be receptive and make an effort to do pleasant things (anticipatory pleasure). It contains 6 items that represent different expression of this construct (e.g. "Almost always I try to enjoy new things every day, though they are small") and that are rated on a Likert scale from 1 ("strongly disagree") to 7 ("strongly agree") (Hervás, et al., 2009).

*2.2.2.3. The Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., in press).* The AAQ-II is a 10-item revision of the original 9-item AAQ that assesses the level of tolerance to distressing mental events such as body sensations, thoughts or emotions (e.g. "I'm afraid of my feelings"). Each item is rated on a 7-point Likert scale ranging from 1 ("never true") to 7 ("always true"). These ratings are summed to obtain a total score. High scores indicate greater EA and psychological inflexibility.

## 3. Results

### 3.1. Demographic characteristics

Demographic variables were analyzed by Pearson chi-square tests ($\chi^2$) for qualitative variables, and by two-tailed independent-samples t-tests ($t$) for quantitative variables (see Table S2 in Supplementary Material). These analyses revealed that there were no significant differences between groups in gender, marital status, educational level, employment status or age.

We also compared clinical variables between groups. Diagnoses did not differ significantly between groups (see Table S2 in Supplementary Material). In addition, there were no significant differences between groups in age at first diagnosis, in the number of psychiatric hospitalizations across their life-span, or in the number of psychiatric hospitalizations during the preceding year.

### 3.2. Current psychiatric symptomatology

Two-tailed independent-samples t-tests were conducted to compare current psychiatric symptomatology for the high-insight and low-insight groups (see Table S3 in Supplementary Material). There were no significant differences between groups in PANSS-N, PANSS-