



The relationship between cognitive insight and quality of life in schizophrenia spectrum disorders: Symptom severity as potential moderator



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ABSTRACT

Cognitive insight is implicated in the formation and maintenance of hallucinations and delusions. However, it is not yet known whether cognitive insight relates to broader outcome measures like quality of life. In the current study, we investigated whether the component elements of cognitive insight—self-certainty and self-reflectiveness—were related to quality of life for 43 outpatients with schizophrenia or schizoaffective disorder. Cognitive insight was assessed using the Beck Cognitive Insight Scale (BCIS) while quality of life was assessed with Quality of Life Scale (QLS). We tested whether this relationship was moderated by clinical insight and symptom severity using the Scale to Assess Unawareness of Mental Disorder (SUMD) and the Positive and Negative Syndrome Scale (PANSS). We found that self-reflectiveness had an unmoderated positive relationship with quality of life. Self-certainty was associated with better quality of life for people with more severe symptoms. Theoretical and clinical implications of these findings are discussed and areas of future research are proposed.

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1. Introduction

Individuals with psychotic disorders tend to show a lack of insight that impacts psychosocial functioning, symptom expression, and treatment outcomes (Mohamed et al., 2009; Riggs et al., 2012; Lysaker et al., 2013). In recent years, researchers have contrasted two kinds of insight: clinical insight and cognitive insight (Donohoe et al., 2009; Lysaker et al., 2013). Clinical insight reflects an understanding or acceptance of different aspects of one's diagnosis (Beck and Warman, 2004; Lysaker et al., 2011b). Cognitive insight, on the other hand, reflects an ability to distance oneself from and evaluate one's own beliefs and interpretations. Cognitive insight is typically divided into the dimensions of self-reflectiveness or the ability to consider the possibility that one's current perceptions and beliefs could be wrong, and self-certainty or confidence in the veracity of one's current perceptions and beliefs (Beck and Warman, 2004; Beck et al., 2004). Cognitive insight is lacking when self-reflectiveness is too low or when self-certainty is too high.

Recent studies have revealed a mixed impact of clinical insight on quality of life, forcing researchers to revise earlier conceptions

of insight as being unequivocally beneficial to people with schizophrenia (Lysaker et al., 1998, 2007b; Hasson-Ohayon et al., 2006; Montemagni et al., 2014). Some preliminary evidence in a sub-clinical sample suggests the possibility that cognitive insight may have a similarly equivocal relationship with quality of life (Weintraub and Weisman de Mamani, 2015), however, the relationship between cognitive insight and quality of life for people with psychotic disorders has yet to be determined. Given that cognitive insight may be affected by psychosocial treatments, it is essential to understand how overall well-being is affected by varying levels of self-reflectiveness and self-certainty.

Some lines of evidence suggest that cognitive insight is related to positive outcomes for people with psychotic disorders. For example, greater cognitive insight is predictive of greater reductions in psychosis with cognitive behavioral therapy (Granholm et al., 2005; Perivoliotis et al., 2010; Premkumar et al., 2011), and lack of cognitive insight is consistently associated with the presence of active delusions (Bora et al., 2007; Warman et al., 2007a; Buchy et al., 2009; Engh et al., 2010). However, greater cognitive insight has also been associated with negative outcomes. Among people with psychotic disorders, cognitive insight appears to be associated with increased self-stigma (Mak and Wu, 2006) and increased anxiety (Colis et al., 2006), though Buchy et al. (2009) did not find an association with anxiety among people with first-episode psychosis. Studies have also shown that cognitive insight

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is generally related to increased depression (Granholm et al., 2005; Colis et al., 2006; Warman et al., 2007a; Uchida et al., 2009; Mass et al., 2012; Palmer et al., 2015), but some researchers measured no relationship between cognitive insight and depression (Beck et al., 2004; Pedrelli et al., 2004; Zimmermann et al., 2005; Engh et al., 2007; Tranulis et al., 2008), and one study reported that greater cognitive insight was associated with decreased depression for people with schizophrenia (Engh et al., 2011). One trial of cognitive behavioral social skills training for schizophrenia found that reductions in self-certainty were correlated with increased depression midway through treatment, but that the association disappeared by the end of treatment (Granholm et al., 2005).

One possible explanation for these equivocal findings is that the impact of cognitive insight upon quality of life depends on the presence of other variables. Two such variables are symptom severity and clinical insight. It is likely that symptom severity moderates the effect of cognitive insight on quality of life because the perspective-taking abilities associated with better cognitive insight would be expected to have very different impacts for persons experiencing different levels of symptom severity. For patients whose symptoms are severe and obvious to others, higher self-certainty may serve as a protective factor against the pervasive social stigma that can interfere with quality of life (Corrigan and Watson, 2002; Corrigan, 2004; Mak and Wu, 2006; Buck et al., 2013). It may therefore be that cognitive insight and symptom severity interact to affect quality of life.

Another potential moderator of the effect of cognitive insight on quality of life is clinical insight. Authors have suggested that clinical insight benefits patients because increased awareness of mental health allows for better adherence to medical recommendations and increased engagement in treatment (Mohamed et al., 2009). While engaged in treatment, those patients with higher cognitive insight may be better able to incorporate the feedback of mental health professionals and consider alternative ways of thinking (De Vos et al., 2015). Supporting evidence for this theory is found in trials of cognitive behavior therapy for psychosis, which consistently find that higher cognitive insight is predictive of better response to psychosocial treatments (Granholm et al., 2005; Perivoliotis et al., 2010; Premkumar et al., 2011). It is therefore possible that clinical insight moderates the effect of cognitive insight on quality of life.

To examine these issues, we gathered concurrent assessments of cognitive insight, clinical insight, symptom severity, and quality of life among patients with schizophrenia spectrum disorders. We formulated four hypotheses. We hypothesized that greater self-reflectiveness would be directly associated with better overall quality of life, while greater self-certainty would be associated with worse overall quality of life. We also hypothesized an interaction between clinical insight and cognitive insight, such that higher cognitive insight would have a positive relationship with quality of life for those patients with high clinical insight. Finally, we hypothesized that symptom severity would moderate the effect of self-certainty on quality of life such that for people with very severe symptoms, self-certainty would have a protective effect on quality of life.

2. Methods

2.1. Participants

This study was approved by the Institutional Review Boards of each of the participating institutions. Individuals with schizophrenia spectrum disorders were recruited from a VA medical hospital as part of a larger study (Warman et al., 2007a, 2007b). In order to participate in the study, participants had to be at least 18 years old and have a diagnosis of Schizophrenia or Schizoaffective Disorder as confirmed by the SCID. All participants were outpatients at the time of testing.

Table 1
Participant characteristics.

	N	%
Gender		
Male	39	90.7
Female	4	9.3
Race		
Caucasian	20	46.5
Black or African American	20	46.5
Native American	2	4.7
Hispanic or Latino	1	2.3
Diagnosis		
Schizophrenia	22	51.2
Schizoaffective	21	48.8
Age	Mean (SD)	Min–max
	48.72 (6.81)	33–62

Research assistants with extensive training in the study procedures assessed participants on the clinician-rated measures described below, and all participants were tested individually. Of the 51 patients who participated, 43 had completed quality of life evaluations allowing them to be used in the present study. Participant characteristics for the present study can be found in Table 1.

2.2. Instruments

2.2.1. The Beck Cognitive Insight Scale (BCIS; Beck et al., 2004)

The BCIS is a 15-item Likert-style self-report measure of patients' self-reflectiveness and self-certainty about their interpretations of experiences. The measure is composed of a 9-item Self-Reflectiveness subscale (BCIS-SR) and a 6-item Self-Certainty subscale (BCIS-SC), with higher scores indicating greater levels of the construct. Self-reflectiveness is operationally defined as the ability to consider the possibility that one's beliefs could be false, while self-certainty is overconfidence in the accuracy of one's current beliefs. The scale demonstrates good convergent, discriminant, and construct validity (Beck et al., 2004; Pedrelli et al., 2004; Bora et al., 2007; Perivoliotis et al., 2010), and studies have found adequate to good internal consistency and test–retest reliability (for review, see Riggs et al., 2012).

2.2.2. The Scale to Assess Unawareness of Mental Disorder (SUMD; Amador et al., 1993)

The SUMD is a clinician-rated measure of insight that uses Likert-style items with higher scores indicating lower clinical insight. The scale captures three key elements of clinical insight – Awareness of having a mental disorder, Awareness of the consequences of illness, and Awareness of the need for treatment – with the sum of the composite items creating a total score. The SUMD is widely used in studies of clinical insight and has been found to have good to excellent interrater reliability and intraclass correlations (Amador and Gorman, 1998; Lysaker et al., 2006; Yanos et al., 2008; Montemagni et al., 2014).

2.2.3. The Quality of Life Scale (QLS; Heinrichs et al., 1984)

The QLS is a 21-item clinician-rated measure of quality of life based on a semi-structured interview. Items are scored on a 7-point scale with higher scores indicating better quality of life. The QLS Total score is the sum of items composing the four subscales: (1) Intrapsychic Foundations, (2) Interpersonal Relations, (3) Instrumental Role, and (4) Common Objects and Activities (Heinrichs et al., 1984). Intrapsychic Foundations consists of items representing a sense of purpose, motivation, curiosity, and empathy. The Interpersonal Relations items capture factors such as capacity for intimacy, active versus passive participation in social activities, and withdrawal or avoidance strategies. Instrumental Role refers to the patient's ability to maintain normative roles such as student, employee, parent, etc. Finally, Common Objects and Activities refers to the patient's engagement in a range of activities and possession of common objects (going to movies, owning a watch). The QLS has been shown to have good to excellent interrater reliability (Lysaker et al., 1998). Additionally, factor analysis (Heinrichs et al., 1984) and theoretically consistent relationships with outcome measures like marital status, housing circumstances, and symptom severity (Norman et al., 2000) suggest good validity.

2.2.4. The Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987)

The PANSS is a widely used clinician-rated measure of psychotic symptoms. The PANSS is composed of Likert-style items ranging from 1 to 7 representing various aspects of psychopathology commonly associated with schizophrenia spectrum disorders. The scales can be summed for a Total Psychopathology score, which has been shown to map well onto independent measures of overall illness severity as well as being sensitive to changes in illness severity over time (Leucht et al., 2005). For the purposes of this study, the PANSS-Lack of Insight item was removed from the PANSS-Total score in order to isolate the effect of cognitive insight (as measured

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