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The Structured Interview for Insight and Judgment in Dementia: Development and validation of a new instrument to assess awareness in patients with dementia

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Abstract

Introduction: Poor insight about their cognitive and functional deficits is highly prevalent in patients with Alzheimer disease (AD); however, there is a lack of reliable, valid instrumentation to measure this construct. The aim of this study was to develop and validate a semistructured interview to assess insight and judgment in patients with AD and to provide information regarding the assessment of competency and risk in this population.

Methods: We validated the Structured Clinical Interview for Insight and Judgment in Dementia (SIJID) in a consecutive series of 124 patients with probable AD. The following psychometric properties were evaluated: internal consistency, test-retest reliability, interrater reliability, and convergent and predictive validity.

Results: The SIJID demonstrated high test-retest, interrater reliability and also showed strong discriminant and convergent validity. It showed good predictive validity based on 1-year follow-up information of the patient's clinical outcomes, with a significant association between higher SIJID total scores at baseline, and more severe neuropsychiatric symptoms and more severe caregiver distress at follow-up. Moreover, higher scores of dangerous behaviors at baseline were significantly correlated with a higher frequency of hospitalization and placement in residential care 1 year later.

Conclusion: The SIJID is a reliable and valid instrument to assess insight and judgment in patients with AD and is a valuable tool for assessing presence and severity of dangerous behaviors, determining risk, and providing critical information for the assessment of competency.

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Keywords:

Dementia; Insight; Judgment; Assessment; Anosognosia

1. Introduction

A large proportion of patients with Alzheimer disease (AD) have anosognosia (i.e., poor insight) about their cognitive deficits, functional limitations, and behavioral changes [1,2]. Prevalence of anosognosia in AD varies between

20% and 80%, depending on different factors such as the assessment method used, sample characteristics, and severity of dementia [3]. Anosognosia is present in the early stages of AD [4] and has been associated with more severe paranoid ideation, irritability, behavioral disinhibition, agitation [5], dangerous behaviors [6], lack of treatment compliance, and caregiver distress, as compared to AD patients without anosognosia [7]. Dangerous behaviors are particularly important as they represent a potential risk for patients and others and may limit the patient's capacity to

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live independently. In a series of 278 patients with probable AD, our group found that 16% had dangerous behaviors and 84% of this group explicitly denied these behaviors, most having anosognosia [6].

Caregivers are often faced with the dilemma of whether to allow patients to engage in activities with potentially harmful consequences or whether to restrict their autonomy. Furthermore, poor insight is among the most powerful predictors of negative outcomes [7] and may contribute to caregiver burden over and above dementia severity and functional impairment. Thus, the assessment of insight in AD has high clinical relevance, when considering not only the impact of this problem on patients and their family but also the social implications of increased need for medical support, and social, legal, and financial services as well [8].

Current clinical practice rarely includes semistructured interviews for psychological and behavioral problems of AD. The paucity of reliable and valid instruments to assess insight and judgment focusing on risk is a limitation in the clinical care of AD patients [9–11].

During the past 30 years, more than 50 instruments have been designed to assess anosognosia in patients with AD, but many of these lack adequate psychometric information [12–14]. Although most instruments measure insight of deficits for specific cognitive functions, usually memory, they do not provide information regarding more global functioning and/or risks [13,15]. Some instruments are very brief [12,16,17] and do not allow for a sound diagnosis of deficits on insight and judgment. Others were originally designed to assess insight in disorders other than dementia, and the validity of these instruments for use in AD remains unknown [18–20]. The main instruments

currently used to assess insight/anosognosia in AD, along with their psychometric attributes, are presented in Table 1.

We developed the Structured Interview for Insight and Judgment in Dementia (SIJID) to examine the patient's performance on a range of basic and instrumental activities of daily living, to assess their current mood and affect, to identify aberrant behaviors, and detect the presence and severity of dangerous behaviors. The SIJID is a semistructured interview that includes questions for both patients and informants and considers information from additional sources such as the patient's clinical records and general practitioner's reports. The aim of the SIJID was to provide reliable and valid information on the patient's level of insight for their physical, psychological, cognitive, and behavioral problems, as well as judgment regarding their capacity to perform basic and instrumental activities of daily living, and the presence and severity of dangerous behaviors, all of which may assist in the assessment of competency. The main aim of this study was to determine the validity and reliability of the SIJID for use in AD and to discuss its potential contribution to the assessment of competency and risk in this patient population.

2. Methods

2.1. Conceptual framework, structure, and scoring method of SIJID

The SIJID was conceived as an evaluative and predictive instrument to assess insight, judgment, and capacity in patients with AD and to also estimate the risk to the patient as a result of engagement in current or potentially dangerous behaviors. Insight of illness was defined as the ability to

Table 1
Summary of psychometric properties of instruments to assess awareness in AD

Name	Sample	Content validity	Internal consistency	Construct validity	Reliability	
					Test-retest	Interrater
AQ-D [21]	N = 750, reliability: 10	+	+	+	?	?
AII [22]	N = 23	+	+	?	0	0
ASPIDD [23]	Pilot study, N = 10; total sample, N = 201	+	+	0	0	0
AC [24]	Pilot study = 40; reliability, N = 12	+	?	+	–	?
AMIS [25]	Baseline, N = 203; control, N = 40	+	+	0	?	0
CIRS [26]	N = 50; interrater reliability = 25	?	+	0	0	?
DDS [27]	Total sample, N = 201	+	+	+	?	?
GRAD [28]	Sample, N = 170; interrater reliability, N = 20	?	+	0	0	?
MARS [29]	Normative data = 236 AD patients and 80 controls	+	+	+	?	?
MIC [30]	Sample, N = 79; reliability = 12, controls = 20	+	+	?	0	?
SCQ [31]	N = 45, reliability = 18	?	0	0	?	?
SED-11Q [32]	N = 107	?	0	?	0	0

Abbreviations: AD, Alzheimer disease; AQ-D, Anosognosia Questionnaire for Dementia; AII, Assessment of Impaired Insight; ASPIDD, Assessment Scale of Psychosocial Impact of the Diagnosis of Dementia; AMIS, Awareness of Memory Impairment Scale; CIRS, Clinical Insight Rating Scale; DDS, Dementia Deficit Scale; GRAD, Guidelines for the Rating of Awareness Deficits; MARS, Memory Awareness Rating Scale; MIC, Memory Inventory for Chinese; SCQ, Self Consciousness Questionnaire; SED-11Q, Symptom of Early Dementia–11 Questionnaire.

NOTE. + = positive, ? = indeterminate (i.e., doubtful design or method; lacking of a clear description of the design or methods of the study, sample size for reliability smaller than 50 subjects, or using Pearson or Spearman correlation coefficients to assess reliability, or no specific hypothesis was formulated to test construct validity or responsiveness, or any important methodological weakness in the design or execution of the study), 0 = no information available [33].

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