

Insight and recovery from psychosis in chronic schizophrenia and schizoaffective disorder patients

Thomas E. Smith^{a,b,*}, James W. Hull^{c,d}, Jonathan D. Huppert^e,
Steven M. Silverstein^{c,d}, Donna T. Anthony^{c,d}, Joel F. McClough^{a,b}

^aDepartment of Psychiatry, Columbia University College of Physicians & Surgeons, New York, NY, USA

^bHall-Brooke Behavioral Health Services, 47 Long Lots Road, Westport, CT 06880, USA

^cNew York-Presbyterian Hospital, Westchester Division, USA

^dDepartment of Psychiatry, Weill Medical College of Cornell University, White Plains, NY, USA

^eCenter for the Treatment and Study of Anxiety, University of Pennsylvania, Philadelphia, PA, USA

Received 10 October 2002; received in revised form 9 June 2003; accepted 26 June 2003

Abstract

Impaired insight is an important contributing factor to poor treatment response and outcome in schizophrenia. Prior studies have attempted to identify the illness characteristics that underlie these deficits, with conflicting results regarding associations with symptoms and neurocognitive deficits. These inconsistencies may be a function of a number of methodological issues, which were addressed in this study. In a prospective, longitudinal study, 50 individuals with schizophrenia or schizoaffective disorder underwent baseline assessments upon discharge from an acute inpatient unit, and again at a 6-month follow-up. Unawareness of positive and negative symptoms were studied separately, with analyses focusing on changes in insight over time as well as associations with disorganized symptoms, depression, and card sorting deficits. Subjects showed greater insight for negative symptoms than for positive symptoms. Insight for positive symptoms improved only slightly over the follow-up period, while negative symptom awareness did not change. Insight for negative symptoms showed modest associations with card sorting deficits, while awareness for positive symptoms showed stronger associations with thought disorder, depression, and card sorting deficits. Awareness for positive symptoms in schizophrenia may be distinct from awareness of negative symptoms. Clinicians should also be aware of the multi-determined nature of impaired insight, and future research should aim to isolate distinct mechanisms that give rise to these deficits. © 2003 Elsevier Ltd. All rights reserved.

Keywords: Insight; Schizophrenia; Positive symptoms; Negative symptoms; Disorganized symptoms; Executive deficits

1. Introduction

Symptom awareness deficits are common in schizophrenia (Amador et al., 1994), and have been associated with poor treatment compliance (Fenton et al., 1997; Smith et al., 1999; Olfson et al., 2000), impaired interpersonal functioning (Lysaker et al., 1998b), and suicidal behavior (Amador et al., 1996; Schwartz, 2000). Studies suggest only weak associations between symptom awareness and positive and negative symptom levels (Amador et al., 1993, 1994; Carroll et al., 1999; Collins et al., 1997; Cuesta & Peralta, 1994; Cuesta et al., 1998;

Debowska et al., 1998; Dickerson et al., 1997; Kemp and Lambert, 1995; Lysaker & Bell, 1994; Peralta & Cuesta, 1994; Schwartz, 1998), while more consistent associations have been documented between symptom unawareness and depression or disorganized symptoms (Cuesta et al., 1998, 2000; Amador et al., 1994; Smith et al., 1998, 2000; Carroll et al., 1999; Moore et al., 1999). Still other studies have suggested associations between executive deficits (trail making and card sorting impairments) and poor insight (Collins et al., 1997; Kemp & David, 1996; Laroie et al., 2000; Lysaker & Bell, 1994; Lysaker et al., 1998a; McEvoy et al., 1996; Mohamed et al., 1999; Smith et al., 2000; Startup, 1996; Young et al., 1993, 1998).

There are several possible explanations for these inconsistent findings. There may be different types of

* Corresponding author. Tel.: +1-203-221-8804; fax: +1-203-226-8616.

E-mail address: tsmith@svhs-ct.org (T.E. Smith).

symptom awareness deficits, with examples including a neurocognitive-based impairment, or a denial of reality as a psychological defense mechanism designed to protect against high levels of anxiety or depression. Another critical question involves awareness for different types of symptoms. The studies reviewed above assessed awareness of global symptom levels, but it is possible that awareness of positive symptoms such as hallucinations and delusions is fundamentally different from awareness of negative symptoms such as flat affect or curbing of interests.

In this study, we attempted to address these conceptual and methodological issues. We used a naturalistic, prospective, design to document changes in symptom awareness in a cohort of individuals with chronic psychotic disorders over a 6-month period following inpatient treatment for acute symptom exacerbations. We assessed awareness for positive and negative symptoms separately, and documented associations between symptom awareness and the three illness-related factors most commonly associated with impaired insight in previous studies: disorganized symptoms, depression, and executive functioning impairments. We hypothesized that there would be differences in awareness for positive vs. negative symptoms, given that there may be differences in the neurobiological correlates for the symptom clusters (Liddle & Morris, 1991; Norman et al., 1997; Strauss, 1993). We also hypothesized that symptom awareness would not change significantly over time, based upon our previous research (Smith et al., 1998). We had no a priori hypotheses regarding correlations between insight predictors and awareness for positive vs. negative symptoms, as there had been no previous insight research making these symptom distinctions.

2. Materials and methods

Subjects were recruited upon admission to an outpatient treatment program, with inclusion criteria including: (a) age 18–50; (b) diagnosis of schizophrenia or schizoaffective disorder; and (c) having been in the hospital for treatment of an acute psychotic exacerbation within 30 days of recruitment. Exclusion criteria included: (a) comorbid diagnosis of substance dependence; (b) estimated IQ less than 70; and (c) any history of serious traumatic brain injury.

After complete description of the study to the subjects, written informed consent was obtained. Fifty individuals gave consent and completed initial assessments of symptoms, neurocognition, and insight. The study design included follow-up assessments of insight at 3-month intervals for up to 12 months. In prior publications we presented data from our baseline assessments (Smith et al., 1999, 2000); in this report we

present data comparing the baseline and 6-month follow-up assessments. The mean interval between assessments for the cohort was 165 days (S.D. = 38.3 days). We chose this 6-month interval for study because it represents a critical period when patients are stabilizing following acute symptom exacerbations. All subjects received routine outpatient care during the study period including monthly medication visits with a psychiatrist along with case management and group psychotherapy as indicated. No efforts were made to control for specific medication or non-medication treatments.

The Structured Clinical Interview for DSM-IV (First et al., 1995) was administered to establish Axis I diagnoses. Thirty-one (62%) of the subjects received a diagnosis of chronic schizophrenia, and 19 (38%) were diagnosed with schizoaffective disorder. Thirty-one (62%) were male, 84% were Caucasian, 14% were African-American, and 1 subject (2%) was of Asian descent. The mean age of the cohort was 37 years (S.D. = 9.5 years), the mean age of illness onset was 18 years (S.D. = 7.7 years), and subjects had an average of seven prior hospitalizations (S.D. = 3.9).

Subjects completed baseline assessments within 14 days of discharge from an inpatient unit. Symptoms were assessed using the Scale for the Assessment of Positive Symptoms (SAPS) (Andreasen, 1984b), the Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1984a), and the expanded Brief Psychiatric Rating Scale (BPRS) (Lukoff et al., 1986). Positive and negative symptom dimension scores were generated from global SAPS/SANS ratings as defined and validated by Andreasen et al. (1995). The SAPS global rating for the formal thought disorder subscale (FTD) was used instead of the disorganized symptom dimension score defined by Andreasen et al. (1995), as this variable was more normally distributed in our cohort. Depression was rating using the single BPRS depression item. Intraclass correlation coefficients for the four raters involved in this study were: positive symptoms: 0.77; negative symptoms: 0.91; formal thought disorder: 0.83; and depression: 0.94.

Executive functioning was assessed using the Wisconsin Card Sorting Test (WCST) (Heaton et al., 1993), with the percentage of perseverative errors variable used in analyses. This variable was chosen as it is among the most commonly used in studies of insight in schizophrenia utilizing the WCST.

Insight was measured using the Scale for the Assessment of Unawareness of Mental Disorder (SUMD) developed by Amador et al. (1993). The SUMD generates ratings of several aspects of insight including awareness of having a mental disorder and awareness and attribution of both current and past symptoms. Subjects' symptoms are elicited from medical record reviews or individual interviews, and the SUMD directs interviewers to clarify beliefs about the presence/

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات