Psychiatry Research 225 (2015) 695–701

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Quality of life in schizophrenia spectrum disorders: Associations with insight and psychopathology

Maria Margariti [a,*], Dimitris Ploumpidis [a], Marina Economou [a], George N. Christodoulou [b], George N. Papadimitriou [a]

[a] University of Athens, 1st. Department of Psychiatry, Eginition Hospital, 72-74 Vas. Sofias Avenue, Athens 11528, Greece
[b] Kapodistrian University of Athens, Emeritus Professor of Psychiatry, Greece

ARTICLE INFO

Article history:
Received 24 February 2014
Received in revised form
25 September 2014
Accepted 7 November 2014
Available online 15 November 2014

Keywords:
Insight
Awareness of illness
Depression
Quality of life
Schizophrenia

ABSTRACT

Therapeutic interventions in chronic mental illness face the important challenge to pursuit the quality of life (QOL) of patients. Insight into chronic mental illness, though a prerequisite for treatment adherence and a positive therapeutic outcome, has shown adverse associations with subjective QOL. This study aims to explore the contribution of psychopathological symptoms on the ambiguous role of insight on QOL.

Seventy-two outpatients with schizophrenia spectrum disorders were assessed using the positive and negative syndrome scale, the scale to assess unawareness of mental disorder, and the WHOQOL-100 instrument for the assessment of quality of life.

Insight was found to associate inversely with quality of life. Among psychopathological symptoms, depressive symptoms were the strongest negative contributor on QOL. Mediation analysis revealed that the effects of awareness of the consequences of illness on QOL were largely mediated by depressive symptoms (full mediation for the effect on physical and psychological domain and partial mediation for the effect on independence and environment domain of the QOL).

Our results suggest that the inverse relationship between insight and subjective quality of life is partially mediated by depressive symptoms. We discuss theoretical and therapeutic implications of the findings, in conjunction with similar recent research data.

© 2014 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Quality of life is viewed as a complex multidimensional construct that encompasses various domains of life, ranging from physical and psychological health to social functioning and the religious beliefs of a person. The different domains are influenced by personal experiences, beliefs, and expectations (WHOQOL Group, 1993).

Subjectivity is inherent in the notion of QOL by definition (WHOQOL Group, 1993; Gill and Feinstein, 1994), though in the case of persons suffering from chronic mental illnesses such as schizophrenia, its validity has often been questioned for various reasons (Atkinson et al., 1997; Doyle et al., 1999). More specifically, a number of authors take into account that psychopathology is likely to affect the patients' responses about their life satisfaction in various domains (Jenkins, 1992; Serban and Cidynski, 1979). It is assumed that psychopathology potentially influences the mental, emotional and social judgment of patients, and as a result of this, it can distort the self-report ratings in QOL (Prince and Prince, 2001; DeHaes et al., 1992; Pavot and Deiner, 1993).

There have been recent evaluations of the impact of depressed mood on subjective QOL of persons with schizophrenia. It has been shown that depressed mood affects, strongly and negatively, the evaluation of their own global QoL, as well as the various domains of their QOL (Fitzgerald et al., 2001; Reine et al., 2003; Sim et al., 2004). The Depression factor of the positive and negative syndrome scale (PANSS) has been found to correlate inversely with global subjective QOL (Dickerson et al., 1997), while higher anxiety and depression ratings as measured by the brief psychiatric rating scale (BPRS) have also been found to correlate inversely with QOL (Huppert et al., 2001; Orsel et al., 2004).

However, the compromised validity of self-administered QOL instruments in chronic mental illness due to psychopathology necessitates reconsideration. This because psychopathological symptoms such as positive and negative symptoms of schizophrenia have been found to account for worse QOL, especially with reference to interviewer assessments of these population groups (Fitzgerald et al., 2001; Bengtsson –Tops et al., 2005). Therefore, it seems that psychopathology plays a significant role not only in subjectively evaluated QOL, but also in externally assessed QOL.

* Corresponding author. Tel.: +30 2106179550; fax: +30 2107242032.
E-mail address: mmarg@med.uoa.gr (M. Margariti).

http://dx.doi.org/10.1016/j.psychres.2014.11.016
0165-1781/© 2014 Elsevier Ireland Ltd. All rights reserved.

Divergence of the implicated symptoms suggests that the two ways of assessment probably measure complementary components, for instance mainly discomfort experienced by patients due to specific symptoms on one hand, and the social and functional impact of psychotic illness assessed by evaluators on the other.

Nevertheless, the influence of these psychopathological symptoms on QOL leads to the same direction. Severity of some aspects of illness produces either less life satisfaction as experienced by the patients, or diminished level of QOL as measured by external evaluators. On the contrary, another psychopathological feature, namely lack of insight, has been speculated to contribute to paradoxically elevated life satisfaction scores in comparison with external evaluations (Jenkins, 1992; Atkinson et al., 1997). The discordance between subjective and externally assessed QOL has largely attributed to this lack of insight (Doyle et al., 1999; Massie et al., 2003;Hasson-Ohayon et al., 2006, 2011).

Lack of insight is a commonly observed phenomenon across psychotic illnesses, subject to various explanatory models. Especially for schizophrenia, it seems to be more pervasive, and is apparent in 50–80% of the patients during the course of their illness (Amador and Gorman, 1998). It seems to describe a complex phenomenon that may implicate a range of factors involving neuropsychological parameters (Young et al., 1993; Lysaker and Bell, 1994; Drake and Lewis, 2003; Koren et al., 2004), coping strategies relevant to psychological denial (Moore et al., 1999; Lysaker et al., 2007), in addition to combinational concepts suggesting the modulating influences of the latter to the first (Cooke et al., 2005).

During the last two decades, insight has also been conceptualized as a complex construct in contrast to the dichotomous approach of the past. Research has demonstrated that there are varying dimensions of insight, including not only recognition of the presence of mental disorder, but also understanding of the consequences of the disorder and appreciating the need for treatment (Amador et al., 1993). Growing evidence also support the fact that unawareness of illness has a negative effect on medication adherence and compliance, social and occupational functioning, and the prognosis and outcome of illness (Mc Evoy et al., 1989; David et al., 1992; Amador et al., 1994; Rossi et al., 2000; Coldham et al., 2002; Perkins, 2002; Yen et al., 2005; Lincoln et al., 2007). Therefore, in the relevant literature, contribution of insight on quality of life has been described as “the insight paradox” indicating the pattern of apparently contradictory associations with the outcome (Lysaker et al., 2007). The reasoning however behind this contradictory effect of insight has –in our opinion– not been clarified yet. Depressed patients for example are expected to downgrade their life due to their depressed mood, but there is not an obvious and clear reason for a person who lacks insight into his/her illness to overestimate globally the various aspects of his/her own QOL. Indeed, we cannot consider self-evident the contribution of awareness in the evaluation of the QOL patient per se. We generally resort to unconfirmed intermediate paths, as for example, through cognitive impairments linked to unaware patients that affect social judgment, minimal aspirations and motivation to change life circumstances again linked to unawareness, or even distress feelings more pronounced to insightful patients. We consider that each one of these assumptions may have a different impact on the concerns for the validity of self-evaluated quality of life. Therefore, we think that in order to understand better this inexplicit association of insight with QOL, we should examine the role of intermediate variables. Indeed, there have been reports in the literature linking the presence of insight to depressive symptoms. These theories, as already mentioned, conceptualize unawareness as being a form of denial, reflecting a psychological defense mechanism (Moore et al., 1999; Crumlish et al., 2005) or a cognitive strategy, where patients are aware of their illness in some sense, but are motivated to deceive themselves in order to preserve their self-esteem and maintain a positive outlook (Startup, 1996). Good insight has been found in several studies to correlate positively with depressive symptoms in the early or acute phase of psychosis, as well as in chronic and stable psychoses (Cooke et al., 2005; Saeedi et al., 2007; Schennach, 2012). This association has also been confirmed in a meta-analysis covering the previous 20 years of published data (Mintz et al., 2003).

Taking into consideration the aforementioned work and hypotheses concerning the relation of depression with insight, as well as the relation of depression to QOL, we hypothesize that depressive symptoms could mediate the effect of insight on subjective QOL. To our knowledge, there is no previous work exploring this interrelationship in a similar sample of patients.

1.1. Aims and hypotheses of the study

I. To investigate any correlations between psychopathological symptoms and subjective QOL. We expected that especially depressive symptoms are negatively associated with QOL.
II. To investigate any correlations of insight with QOL. We expected that insight would inversely correlate with QOL.
III. To investigate whether insight correlates with depressive symptoms. If such an association exists, we expect an inverse association (the more insightful a person, the more depressed he/she should be).
IV. In case of an association between depressive symptoms and insight items, to further investigate whether insight continued to contribute to QOL while controlling for the effect of depressive symptoms.

2. Method

2.1. Subjects

For this cross-sectional study, participants were recruited from two rehabilitation programs of our institution, located in the community of the Athens area. The study group consisted of 72 subjects of Greek ethnicity, at their entrance in the program, who received diagnoses of schizophrenia (*N*: 61) and schizoaffective disorder (*N*: 11) according to DSM-IV by consent of two psychiatrists and using all sources of information available (patients' clinical history and records, illness course, and psychiatric interview). Inclusion criteria for the study were a stable psychopathological condition under psychotropic medication (all subjects were judged to be stable on their medication regimen for at least 1 month). Exclusion criteria were alcohol or drug abuse and history of serious brain injury or other organic brain pathology.

Of the 72 subjects, 41 were men and 31 were women, their age range 18–55, with a mean of 35.54 (S.D. = 7.89 years). The study was carried out in accordance with the code of ethics of the WMA (Helsinki Declaration, revision 2008) and the subjects gave written informed consent before their inclusion in the study.

2.2. Assessments

Psychopathology was assessed by the positive and negative syndrome scale (PANSS) (Kay et al., 1987; Lykouras et al., 1997). PANSS is a widely used, 30-item scale for assessing schizophrenic symptoms. It is composed of three subscales: positive (score ranges: 7–49), negative (score ranges: 7–49), and general psychopathology (score ranges: 16–112). Intraclass correlation coefficients' reliabilities for the PANSS items ranged from 0.90 to 0.96.

We used the depressive factor (sum of items G1, G2, G3, and G6; score ranges 4–28), calculated according to the author (Kay, 1991) for the assessment of depressive symptoms, since it has proven its efficiency for estimating depression in schizophrenia (Yazaji et al., 2002).

Insight was assessed by the scale to assess unawareness of mental disorders (SUMD) (Amador et al., 1993, 1994; Amador and Kronengold, 2004), using the Greek version (Margariti et al., personal communication, 2000, 2002). SUMD is a semi-structured interview and scale that attempts to assess present and past awareness of illness. SUMD was designed to evaluate the multidimensional nature of insight and consists of three general items assessing: (a) general awareness of mental disorder, (b) awareness of the effects of medication, and (c) awareness of the consequences of mental disorder. Scores are rated on a five-point scale

Download English Version:

https://daneshyari.com/en/article/10304203

Download Persian Version:

https://daneshyari.com/article/10304203

Daneshyari.com