



Socially naïve self-appraisal moderates the relationship between cognitive insight and positive symptoms in schizophrenia

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ABSTRACT

Cognitive insight refers to awareness of one's own thinking. Research has found deficits in cognitive insight in schizophrenia but studies of its links with positive symptoms and delusions have been equivocal. One possibility is that the association of cognitive insight with positive symptoms and delusions is moderated by other factors. To explore this issue this study examined whether level of socially naïve self-appraisal moderated the relationship of two forms of cognitive insight, self-reflectivity and self-certainty with delusions and positive symptoms. Participants were 92 adults, with diagnoses of schizophrenia or schizoaffective disorder, who were administered the Positive and Negative Syndrome Scale, self-deceptive subscale from the Marlowe–Crowne Social Desirability Scale and the Beck Cognitive Insight Scale. Stepwise multiple regressions with the interaction term of the predictive and moderator variables suggested that social naïveté moderates the relationship between self-reflectivity and self-certainty with positive symptoms in general. Moreover, association between self-certainty and delusions was also moderated by social naïveté self-appraisal. All models were significant after controlling for willful impression management as well as a measure of executive function. Results suggest that higher levels of self-certainty are a risk factor for having greater positive symptoms including more severe levels of delusions, when one has a view of oneself that is not tempered by the perceptions of others. Concerning lower levels of self-reflectivity it may be that this combined with a socially naïve view of oneself leaves persons less inhibited when they are tempted to accept unusual thoughts and perceptions as accurate. Implications for treatment are discussed.

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1. Introduction

Persons with schizophrenia commonly display lack of awareness of, or difficulty making judgments about whether they experience symptoms, have a mental illness and whether they need treatment. This phenomenon, referred to as lack of awareness and poor insight, is of clinical importance given its links to treatment adherence, community tenure and psychosocial functioning (Cuffel et al., 1996; Francis and Penn, 2001; Olfson et al., 2006; Erickson and Lysaker, 2012). Insight though is a complex phenomenon which is also linked to adverse outcomes such as decreased emotional well-being and suicidality and researchers have increasingly suggested that it is best not studied as a unitary phenomenon but composed of a range of different dimensions as well as discernibly different components (Evren and Evren, 2004; Crumlish et al., 2005; Hasson-Ohayon et al., 2006).

One effort to clarify the nature of insight in schizophrenia has attempted to distinguish cognitive insight from clinical insight, or awareness of symptoms and need for treatment (Beck et al., 2004). Cognitive insight refers to the ideas persons form about their own judgment and reasoning processes (Martin et al., 2010). It represents a form of reflection about the nature of one's thinking though not necessarily conclusions about how one's mental states should be characterized. Cognitive insight has been hypothesized to be of particular relevance in schizophrenia given that without an ability to appraise the limits of one's own thinking it would seem difficult to question delusional beliefs resulting in their natural intransigence. For instance, a tendency to think about one's own mental processes as infallible might lead an individual with schizophrenia to accept fleeting paranoid thoughts as factual, resulting in unawareness of or lack of insight into symptoms and treatment need (Greenberger and Serper, 2010). Thus cognitive insight is hypothetically a set of cognitive internal processes which should play a role in the expression of what has been traditionally referred to as clinical insight (Riggs et al., 2010).

To date, the key instrument used to assess cognitive insight is the Beck Cognitive Insight Scale (BCIS; Beck et al., 2004). The BCIS distinguishes two forms of cognitive insight: self-reflectivity and self-certainty. Using this scale it is presumed that persons with more cognitive insight are

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more self-reflective and less self-certain. Research using this scale has indeed found greater deficits in cognitive insight in persons with psychosis relative to those without serious mental illness (Martin et al., 2010). Work on the links though between cognitive insight and positive symptoms, especially delusions, has been equivocal. Several studies have found that lower self-reflectivity was linked to indices of greater delusional beliefs (Warman et al., 2007; Engh et al., 2010; Perivoliotis et al., 2010). Buchy et al. (2009), however, found that schizophrenia patients with significant levels of delusions had greater levels of self-reflectivity compared to schizophrenia patients without delusions. Others have not found a relationship between self-reflectivity and positive symptoms (Pedrelli et al., 2004; Favrod et al., 2008; Tranulis et al., 2008). Concerning self-certainty, the literature has been somewhat more consistent. At least five studies have linked higher levels of self-certainty with positive symptoms (Pedrelli et al., 2004; Bora et al., 2007; Warman et al., 2007; Engh et al., 2010; Perivoliotis et al., 2010), though Granholm et al. (2006) and Favrod et al. (2008) did not replicate this. Of note, two other studies of first episode patients yielded no significant relationship between self-certainty and psychotic symptoms (Tranulis et al., 2008; Buchy et al., 2009).

One explanation for these mixed findings is that the relationship between cognitive insight and positive symptoms is moderated by other factors. In other words, the presence of low levels of self-reflectivity and/or of high levels of self-certainty may be a risk factor for positive symptoms when certain other conditions are present. One possible variable which may moderate the impact of cognitive insight on positive symptoms is the extent to which one's general self-appraisal is informed by or in touch with social perceptions. In particular, we hypothesized that low levels of self-reflectivity and high levels of self-certainty might be linked to greater levels of positive symptoms, and delusions in particular, when persons generally have a relatively socially naïve view of themselves. By a relatively naïve self-appraisal we refer to the routine formation of positive beliefs about the self which are unchecked by social norms. Examples of socially naïve self-appraisal include beliefs that one has never been jealous of another's good fortune or that one has never felt resentful when frustrated. Of note, socially naïve forms of self-appraisal reflect a lack of awareness and not willful impression management or purposeful misrepresentation in order to create a certain impression.

We anticipated that the social naiveté of self-appraisal might moderate the impact of cognitive insight on the severity of positive symptoms and delusions for several reasons. For one, the social naiveté of self-appraisal would seem by definition to suggest an unawareness, if not imperviousness, to how one is perceived by others. Thus one's self-certainty might well seem more likely to prevail if protected from awareness of how others see specific beliefs as implausible. Similarly with low self-reflectivity, a lack of connection between other's view of oneself and one's own view of oneself might again result in missed opportunities to correct beliefs others see as implausible. While this has not been studied in schizophrenia to our knowledge, the potential link of self appraisal with positive symptoms is consistent with other research. For instance, one of the Minnesota Multiphasic Personality Inventory's (MMPI-2) scales developed by Harris and Lingoes is the paranoid scale which is composed by three subscales: persecutory ideas, poignancy and naiveté. So, naiveté has already been suggested to be a component associated with positive symptoms (Butcher et al., 1989). We focused on delusions specifically given that they represent beliefs about beliefs and thus of all the positive symptoms might be most closely influenced by cognitive insight.

To test this possibility we gathered concurrent assessments of cognitive insight, positive symptoms in general, delusions and socially naïve self-appraisal. We anticipated that greater levels of socially naïve self-appraisal would facilitate a stronger relationship between self-certainty and self-reflectivity with positive symptoms in general and specifically with delusions. To rule out the possibility that we were not just assessing willful impression management we planned

to include an assessment of intentional impression management as a covariate in all moderation analyses. To explore the possibility that any observed findings were the result of impairments in executive function, we included a measure of this construct for potential use as a covariate.

2. Methods

2.1. Participants

Participants were 80 adult men and 12 women with DSM-IV diagnoses of schizophrenia ($n = 53$) or schizoaffective disorder ($n = 39$) as confirmed by the Structured Clinical Interview for DSM-IV (SCID). The participants comprised the full sample of persons enrolled in a larger study seeking to develop a cognitive behavioral therapy targeting work function in schizophrenia. All were recruited from the outpatient Psychiatry Service of a VA Medical Center ($n = 70$) or Community Mental Health Center ($n = 22$) and were in a post-acute phase of illness as defined by having no hospitalizations or changes in medication or housing in the month before entering the study. Excluded from the study were participants with mental retardation or active substance abuse. The mean age and education of the sample were 48.89 (8.4) and 12.79 (1.7) years, respectively. Ethnic breakdown was as follows: Caucasian, $n = 43$; African-American, $n = 48$; and Latino, $n = 1$. This sample was obtained after a total of 100 potential participants were recruited for the study and only 8 declined to complete some or all of the procedures (refusal rate of 8%).

2.2. Instruments

2.2.1. Positive and Negative Syndrome Scale (PANSS; Bell et al., 1994)

The PANSS assesses the severity of symptoms and consists of 30 items rated on a 7-point scale, and it's broadly used to measure psychopathology. Several factor-analytic studies have suggested that a five-factor model better captures the nature of psychopathology in schizophrenia samples (Wallwork et al., 2012). This study examined one factor from a pentagonal model of the PANSS namely the positive component and one item from that scale, the delusions item (Bell et al., 1994). Inter-rater reliability was assessed for the Positive Component and determined to be 0.66.

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

BCIS is a 15 item self-report measure that assesses how individuals evaluate their own judgment. Previous investigations have derived two factors: self-reflectivity which measures objectivity, reflectiveness and openness to feedback, interpreted as an expression of introspection and willingness to acknowledge fallibility; and self-certainty which measures mental flexibility and patient's certainty about beliefs or judgments. The original study that validated the BCIS reported a coefficient α for the self-reflectivity scale of 0.68 and for self-certainty of 0.60. In the present sample items of the self-reflectivity subscale demonstrated a reliability coefficient of 0.69 and the items of self-certainty subscale obtained a Cronbach's alpha of 0.65.

2.2.3. Marlowe–Crowne Social Desirability Scale (MCSDS; Crowne and Marlowe, 1960)

The MCSDS is a self-report measure of 33 items that participants are asked to endorse as true or false regarding their own experiences. Items reflect culturally sanctioned behaviors that are nevertheless unlikely to occur. Higher scores suggest a need to obtain approval by responding in the perceived culturally approved manner. A two factor model has been proposed by Ventimiglia and MacDonald (2012). The first factor, impression management, reflects instances in which individuals knowingly respond in a manner that creates a favorable self-representation to others. The second factor, self-deception, reflects a genuinely naïve self appraisal and not one which is

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