



Insight and illness perception in Mexican patients with psychosis



Lizzette Gómez-de-Regil*

Hospital Regional de Alta Especialidad de la Península de Yucatán, Mérida, Yucatán, México

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ABSTRACT

Background: Insight and illness perception are two concepts of interest in the study of factors related to clinical outcome in patients with psychosis. Insight implies a risk of emotional distress for the patient. Illness perceptions, regardless of their accuracy, might be favorable or not to illness. Literature provides evidence of significant correlates of these factors with clinical outcome, but they are rarely included in a single study.

Objectives: 1) assessing insight and illness perception in a sample of Mexican patients who have experienced psychosis and, 2) analyzing how insight and illness perception relate to each other and how they relate to clinical status (i.e., positive, negative, and general psychopathology, depression, and anxiety).

Methods: Sixty-one participants (55.7% females) were recruited from a public psychiatric hospital; insight and illness perceptions were assessed with the SUMD and the Brief-IPQ, respectively. Clinical status was assessed with the PANSS, CDS and BAI scales.

Results: Participants showed good insight, favorable illness perceptions for the cognitive and comprehension dimensions, but unfavorable for the emotional dimension. Clinical status of sample was characterized by mild symptoms. Poor insight related to positive symptoms and general psychopathology. Cognitive and emotional perceptions of illness were significantly associated to most clinical status parameters, whereas comprehension showed no significant results.

Conclusions: The study not only replicates the significant association on insight and illness perception with clinical outcome, but shows how their patterns of interactions are different, reinforcing the idea that they are two distinct factors worthy of being habitually acknowledged in research and clinical practice.

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1. Introduction

Most patients with schizophrenia report partial or total awareness of their disorder (Buckley et al., 2007; Jablensky et al., 1992; Lincoln et al., 2007). In the past, insight used to be approached as either present or not present; nowadays, amongst the different conceptual lines, it is agreed that insight is multi-dimensional and varies throughout the illness course (Buckley et al., 2007; Cooke et al., 2005; Osatuke et al., 2008). Moreover, although most available measures of insight rely totally or partially on the clinician's perspective, it has been recognized that poor insight may be incoherent or incomplete for many different reasons which can only be studied through the individual's personal narrative (Lysaker et al., 2002; Roe et al., 2008; Tranulis et al., 2009). Discrepancies between the clinician's and the patient's points of view regarding illness can be approached with standardized insight measures, nevertheless these methods may not be sensitive enough to differentiate between profiles of narrative insight reflecting each person's cultural background, life experiences, and other social determinants (Lysaker et al., 2009; Roe et al., 2008; Tranulis et al., 2008).

Although its dynamic nature challenges research, the literature regarding its etiology has followed four main models: 1) clinical, poor insight is either a primary symptom itself or somehow related to another symptom; 2) neuropsychological, poor insight is due to brain deficiencies; 3) psychological, poor insight is a coping strategy against distress; and 4) social, insight level is influenced by the social context in which it is assessed (i.e., insight is rated by the clinician according to a perception of the difference between his view and the patients'). These models are supported by empirical data and are not necessarily mutually exclusive (Chakraborty and Basu, 2010; Cooke et al., 2005; Osatuke et al., 2008; Raffard et al., 2008). More recent models suggest poor insight is shaped and sustained by multiple factors, including neurocognition (deficits in memory and executive function hinder the recollection and coherent account of historical events related to illness), social cognition (processes involved in thinking about social interactions such as theory of mind, emotion processing and attribution), metacognition (activities involving thinking about thinking, representations of self and others), and stigma (devaluing beliefs about having a mental disorder) (Lysaker et al., 2013b). Along with these original interpretations a number of innovative integrative treatment approaches have been proposed, including the use of personal narratives (Lysaker et al., 2002, 2009, 2013a, 2013b).

Reported clinical correlates of insight are diverse: illness severity, psychotic symptoms, depression, treatment adherence, functioning,

* Hospital Regional de Alta Especialidad de la Península de Yucatán, Calle 7, No. 433 por 20 y 22, Fracc. Altabrisa, Mérida, Yucatán, México, 97130. Tel.: +52 999 942 7600; fax: +52 999 254 3535.

E-mail address: gomezderegil@gmail.com.

quality of life, violence, competence to consent, impaired social skills, reduced work performance, increased rates of psychotic relapse, and risks of suicidal and violent behaviors, among others (Buckley et al., 2007; Chakraborty and Basu, 2010; Drake, 2008; Segarra-Echebarría et al., 2010).

There is an apparent direct connection between poor insight and poor treatment adherence, and, consequently, with poorer outcome and functioning; although this pattern seems rather unstable in the long term (Buckley et al., 2007; Lincoln et al., 2007; Segarra-Echebarría et al., 2010). Psychosocial and pharmacological interventions have been implemented to improve the patients' level of insight (Buckley et al., 2007); nevertheless, the achievement of adequate insight often poses a different set of problems including demoralization, hopelessness, depression, low self-esteem and high suicide rates (Cavelti et al., 2014; Crumlish et al., 2005; Dantas and Banzato, 2007; Lincoln et al., 2007; Lysaker et al., 2013b; Schwartz and Smith, 2004), which must be considered. Thus, clinical practice faces a challenging paradox: higher insight is associated with positive outcomes, such as better treatment adherence and recovery, and negative outcomes, such as depression, hopelessness, low self-esteem and low quality of life. Research has not only replicated this pattern, but also supported self-stigma, social cognition and metacognition as key moderating factors (Cavelti et al., 2012b; Lysaker et al., 2007, 2013a, 2013b; Misdrahi et al., 2014; Schrank et al., 2014).

When experiencing an illness some patients might be at least partially aware of it whereas others might not; nevertheless, they all have an appraisal of their health status and behave accordingly. Illness perceptions, sometimes referred to as beliefs, appraisals, or representations, refer to thoughts, whether accurate or not, that a patient has about his health problems (Cavelti et al., 2012a). Cognitive representation was the first proposed dimension of illness perception, involving beliefs about the cause of the illness, the expected physical consequences, the illness's emotional or functional effects on life, the extent to which the patient believes he can recover from it, if recovery will occur with or without treatment, how the illness and its symptoms are identified and named, and ideas about how long it will last (Lau et al., 1989; Leventhal et al., 1984). Later, the emotional dimension, which focuses on negative reactions such as fear, anger, and distress, is added, along with the understanding/comprehension dimension (Broadbent et al., 2006).

Psychosis, whether perceived as an illness or not, raises the individual's beliefs involving not only the acknowledgement of his health, but also the appraisal of personal and social consequences (Watson et al., 2006). In the presence of symptoms, patients might recognize that "something is wrong", naming it "stress", "nervousness" or "a period of difficulties". A patient might even seek and accept treatment by himself and still not be willing to acknowledge a mental illness; this might be due to denial, fear of stigmatization, a limited educational level, or even to low symptoms severity. Interest in the study of illness perceptions in patients with schizophrenia and related psychoses has encouraged research from diverse countries such as the United Kingdom (Freeman et al., 2013; Karatzias et al., 2007; Lobban et al., 2004, 2005; Shah et al., 2009; Theodore et al., 2012; Watson et al., 2006; Williams and Steer, 2011), Germany (Cavelti et al., 2012a), Turkey (Güner, 2014), and New Zealand (Sanders et al., 2011), with quantitative (e.g., Williams and Steer, 2011) as well as qualitative methods (e.g., Güner, 2014). Results have shown significant correlations between positive and negative psychotic symptoms (Cavelti et al., 2012a; Lobban et al., 2005), anxiety and depression (Cavelti et al., 2012a; Karatzias et al., 2007; Lobban et al., 2004, 2005; Watson et al., 2006), functioning (Lobban et al., 2004), engagement with treatment (Freeman et al., 2013; Shah et al., 2009; Williams and Steer, 2011), coping style, satisfaction with mental health (Lobban et al., 2004), self-esteem (Watson et al., 2006), and quality of life (Lobban et al., 2004; Theodore et al., 2012).

Although at some point insight and illness perception might overlap, results suggest that they are two fairly different constructs thus, they

would relate differently to outcome (Cavelti et al., 2012a; Watson et al., 2006). Nevertheless, they are not usually considered simultaneously when performing a research study in psychosis. The present study aimed at: 1) assessing insight and illness perception in a sample of Mexican patients who have experienced psychosis and, 2) analyzing how insight and illness perception relate to each other and how they relate to measures of clinical status (i.e., positive, negative, and general psychopathology, depression, and anxiety). It was hypothesized that the correlations between insight and illness perceptions would be neither strong ($r \geq 0.70$) nor significant ($p \leq 0.05$). Moreover, clinical status would show some significant ($p \leq 0.05$) and at least moderate ($r \geq 0.40$) correlations with insight and illness perception, but the patterns of associations with these two factors would not be alike.

2. Methods

2.1. Sample

Participants were recruited from a public psychiatric hospital providing mental health services to anyone in need regardless of place of residence and medical insurance conditions. Formal authorization and ethical approval was provided by the Hospital Committees.

Inclusion criteria were: i) age at onset 16–45 years old, ii) a primary current DSM-IV-TR (American Psychiatric Association, 2000) diagnosis of schizophrenia or other schizophrenia-spectrum psychotic disorder, and iii) inhabitant of the city of Merida, where the hospital is located. Exclusion criteria were: i) a DSM-IV-TR diagnosis of psychosis of affective, organic, or toxic type (American Psychiatric Association, 2000), ii) evident intellectual disorder, and iii) inadequate contact information.

Following the above-mentioned criteria, clinical files were reviewed resulting in 161 potential cases. Only 103 could be contacted (3 had passed away, 55 no longer lived in the area or could not be located); 66 (64%) agreed to collaborate.

2.2. Measures

Insight was assessed using the three general items of the Scale of Unawareness of Mental Disorder (SUMD) (Amador and Strauss, 1990; Amador et al., 1993; Ruiz et al., 2008): 1) awareness of mental disorder, 2) awareness of achieved effects of medication, and 3) awareness of social consequences of mental disorder. Higher scores, based on a scale of 1–5, reflect poorer insight.

Illness perception was assessed with the Brief Illness Perception Questionnaire (Brief-IPQ) (Broadbent et al., 2006; Pacheco-Huergo et al., 2012). This self-report Likert Scale includes eight items regarding the three dimensions of illness perception: cognitive representation ("Illness affects my life", "Illness will last long", "I control my illness", "Treatment is helpful to my illness", "I experience severe symptoms from my illness"); emotional representation ("I am concerned about my illness", "Illness affects me emotionally"); and comprehensibility ("I understand my illness"). Higher scores (1–4) of cognitive and emotional representations indicate an unfavorable perception of illness, whereas higher scores of comprehensibility reflect satisfactory understanding of the disorder.

Current clinical status was assessed with the Positive and Negative Syndrome Scale (PANSS) (Kay et al., 1987; Peralta and Cuesta, 1994), which comprises three subscales: positive (7 items), negative (7 items) and general psychopathology (16 items). The severity of 30 symptoms is rated from 1 (absent) to 7 (extreme). Additionally, depression and anxiety were assessed using the Calgary Depression Scale (CDS) and the Beck Anxiety Inventory (BAI), respectively. The CDS (Addington et al., 1990, 1992; Ortega-Soto et al., 1994; Sarró et al., 2004) is a nine-item structured interview scale specifically developed to assess depression in schizophrenia patients, in which each item is scored from 0 (absent) to 3 (severe). A general score (0–27) is obtained by adding up all item scores. The BAI (Beck et al., 1988; Robles et al.,

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