Journal of Affective Disorders 167 (2014) 74–79

Contents lists available at ScienceDirect

Journal of Affective Disorders

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

Research report

The impact of insight in a first-episode mania with psychosis population on outcome at 18 months

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ARTICLE INFO

Article history:
Received 21 January 2014
Received in revised form
24 May 2014
Accepted 25 May 2014
Available online 2 June 2014

Keywords:
Insight
First-episode
Mania
Prognosis
Bipolar disorder

ABSTRACT

Background: To explore whether poor initial insight during a first episode of mania with psychotic features was predictive of poor psychosocial and clinical outcomes at 18 months.
Methods: Secondary analysis was performed on data collected during an 8-week RCT comparing the efficacy of olanzapine versus chlorpromazine as an adjunct to lithium, and at 18-month follow-up. 74 participants were divided into three groups (no insight, partial insight, and full insight) according to the insight item from the Young Mania Rating Scale (YMRS). Differences between these three groups were examined at baseline and at 18 months on measures of symptoms (YMRS, HAMD-21, and CGI-S), and social and occupational functioning (SOFAS). Baseline differences between the three groups were determined using general linear models and chi-squared analyses. Group differences from baseline to 18-month follow-up were determined using repeated measures general linear models.
Results: At baseline there were significant differences between the three insight groups in terms of mania and functioning, but at 18 months all groups had improved significantly in terms of psychopathology, mania, depression and social and occupational functioning. There were no significant differences between the three groups at study completion with respect to these domains.
Limitations: The study was limited by the lack of availability of a more detailed rating scale for insight, and it did not account for the duration of untreated psychosis (DUI).
Conclusions: Poor initial insight during a first episode of mania with psychotic features does not predict poor clinical and psychosocial outcome at 18 months.

1. Introduction

In Homer's *Odyssey*, the sorceress Circe warns Odysseus about the perils he will face sailing into the Sirens' domain; how men have been lured to their deaths on the rocks below through the enchantment of their song. Yet, Odysseus is curious. Knowing that the song will overcome his reason, he orders his men to strap him to the mast and not let him go, no matter how much he protests, whilst the crew plug their ears with beeswax. As they sail through, the song is beautiful, intoxicating, urging Odysseus to sail closer. But as Odysseus thrashes and rails, the deafened crew row on. As the spell fades, Odysseus regains his faculties and is released. They are safe (Homer, 1997).

Homer's classic story richly illustrates the complexity of insight as a psychological concept, demonstrating that in Odysseus's case at least, it is 'state-dependent': madness ensues, insight diminishes; symptoms ameliorate and insight returns. Yet theories of insight delve deeper, and the aetiology of poor insight remains only partially understood. There is broad agreement that insight is a multi-dimensional, as opposed to a binary phenomenon, in that a person is not simply 'insightful' or 'insightless' but exhibits degrees of understanding and awareness in various domains, depending on the clinical stage of illness or remission (Yen et al., 2007). David (1990), illustrates this in his definition of insight, that

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http://dx.doi.org/10.1016/j.jad.2014.05.055
0165-0327/

it is an "awareness that one is suffering, in a general way, from a mental (as opposed to a physical) disturbance which could be an illness; more specific awareness that certain experiences including beliefs and perceptions may not be veridical, and further that they too could be part of an illness; acknowledgement of the medical implications of the above, a concrete token of which is informed acceptance of treatment" (cited in Surguladze and David, 1999,).

De Hart et al. (2009), and Bressi et al. (2012), described three models to explain the aetiology of poor insight. The *clinical model* recognises poor insight as a symptom of mental illness (Amador et al., 1994), whilst the *psychological model* frames poor insight as a coping strategy because greater degrees of insight are associated with worse depressive symptoms (Amador et al., 1994; Pyne et al., 2001). Finally, the *neuropsychological model* describes how executive function and memory play a part in framing current aberrant phenomena in the light of past experience, and if there are deficiencies in these cognitive functions, poor insight may result (Yen et al., 2008,b).

Lack of insight into illness is common across many psychiatric disorders. Individuals with schizophrenia often suffer a lack of insight (Amador and Gorman, 1998) and poor insight has been found to predict adverse clinical and psychosocial outcomes in this population (Amador et al., 1994; Yen et al., 2002). In a study of first-episode schizophrenia patients by Mutsatsa et al. (2006), there was a positive correlation between greater levels of global insight and depressive symptoms. The authors describe this association in the context of 'depressive realism' (a term originally coined by Alloy and Abramson (1998)) – i.e. "depressed individuals will view themselves more realistically and accurately", whilst "non-depressed individuals have an optimistic cognitive bias that produces an exaggerated belief in their own abilities" (Mutsatsa et al., 2006). Mood symptoms aside, in the schizophrenia population the link between insight and recovery is less likely to be as synchronous *over time* (McGorry and McConville, 1999). There is some suggestion that as schizophrenic patients journey through remission their level of insight increases independently to their (objective) improvement in symptoms such as delusions and hallucinations (Jørgensen, 1995), or even remains impaired. In other words, in schizophrenia, insight appears to be a trait-like condition (Ghaemi and Rosenquist, 2004).

On the other hand, insight in *bipolar disorder* appears to be state-dependent; it waxes and wanes depending on illness severity, or more specifically with proximity to the manic-end of the spectrum (Ghaemi and Rosenquist, 2004). Interestingly insight is largely intact during episodes of non-psychotic depression (mirroring 'depressive realism' seen in schizophrenia) (Ghaemi et al., 1997), whilst it is usually impaired during manic episodes (Ghaemi et al., 1995). This may lead to over-reporting of depressive symptoms and under-reporting of manic symptoms, thereby affecting diagnostic accuracy (Ghaemi and Rosenquist, 2004).

The concept of the 'manic defence' suggests that mania may be a psychologically protective mechanism (Klein, 1974), with recognition that a "…gross failure in self-evaluation…" can be common (Cassidy et al., 2001). Some researchers have described a more neuropsychological perspective suggesting that cognitive deficits in insight occur outside a person's awareness (McGorry and McConville, 1999). However, it is notable that while improving insight has traditionally been viewed as a goal, if not a prerequisite of treatment for mania, such improvements can have both positive and negative consequences for this patient group (Macneil et al., 2009).

The question of whether there is a *predictive* value to impaired insight in bipolar disorder, in relation to clinical and psychosocial outcomes, remains unanswered. Yen et al. (2008a), followed a cohort of bipolar I patients over 2 years, and found that insight, in terms of acknowledgement of the illness and relabelling of psychotic phenomenon at baseline, did not have any significant effect on adverse clinical outcomes. However, they also found that initial impaired insight into the *validity of treatment*, as well as increased numbers of prior hospital admissions, were independent predictors of symptom severity at follow-up (Yen et al., 2008a). This may reflect lack of confidence in pharmacotherapy, subsequent lack of compliance and a fatalistic approach to the chronicity of the condition (Bressi et al., 2012).

It is important then to understand insight in a first-episode psychotic mania population, a sample that has not been influenced by prior experience of the mental health system, because if poor initial insight during the *first* episode predicts worse outcomes over time, this could be a useful intervention point. To the best of our knowledge, research into the relationship between initial insight (assessed at first presentation to psychiatric services) and longitudinal psychosocial/clinical outcomes, specifically within the first-episode psychotic mania group, is scant. Many of the previous studies in the literature have been cross-sectional in nature, with patients not necessarily recruited at the same phase of illness. This subjects them to confounders, including exposure to prior treatment.

Thus, the aim of this study was two-fold: (i) to examine difference between three insight groups (insight, partial insight, and full insight) on demographics and clinical variables; and (ii) to delineate whether insight during the first episode of psychotic mania predicted 18-month symptomatic and functional outcomes. It was expected that poor insight would be prevalent in individuals experiencing the acute symptoms of first episode mania. It was further predicted, that those with lower levels of insight during first episode mania will have more severe psychopathology, higher levels of mania, lower depression, and lower levels of social and occupational functioning at 18-month follow-up.

2. Method

2.1. Design

This study involved secondary analysis of data collected for a randomised controlled trial (RCT) which involved comparison of olanzapine versus chlorpromazine as an adjunct to lithium in the treatment of a first-episode manic episode with psychotic features (Conus et al., 2009). The treatment phase ran over 8 weeks, with follow-up occurring up to 18-months post treatment (Macneil et al., 2012).

A detailed description of the demographics and method for the RCT has been described elsewhere (Conus et al., 2009), but some elements are worth emphasising in relation to the present study.

2.2. Patient population

Participants were males and females aged between 15 and 28 who were admitted to the Early Psychosis Prevention and Intervention Centre (EPPIC), Melbourne, Australia for the treatment of a first episode of psychotic mania. All patients admitted between October 2001 and February 2006, with their first episode of psychotic mania, were assessed against inclusion/exclusion criteria. All participants were diagnosed with a first manic or mixed episode with psychotic features within bipolar I or schizoaffective disorder, as per DSM-IV criteria (American Psychiatric Association, 1994). A minimum baseline Young Mania Rating Scale score of 20 or more was also required, as was informed consent. However, to avoid selection bias, and in accordance with local Ethics Committee guidelines, those involuntary participants who lacked capacity were consented by the authorised treating psychiatrist on their behalf, until such time as they clinically