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Insight and gender in schizophrenia and other psychoses

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A B S T R A C T

This study aimed to evaluate gender differences in the deficit of insight in psychosis and determine influences of clinical, functional, and sociodemographic variables. A multicenter sample of 401 adult patients with schizophrenia and other psychotic disorders who agreed to participate was evaluated in four centers of the metropolitan area of Barcelona (Catalonia). Psychopathological assessment was performed using the Positive and Negative Syndrome Scale Lindenmayers' Factors. Insight and its dimensions were assessed by means of the Scale of Unawareness of Mental Disorder. Significant differences were apparent neither between men and women in the three dimensions of insight, nor in the total awareness, nor in the total attribution subscales. However, statistically significant differences were found in awareness and attribution of particular symptoms. Women showed a worse awareness of thought disorder and alogia and a higher misattribution of apathy. Higher cognitive and positive symptoms, early stage of the illness, and having been married explained deficits of insight dimensions in women. In men, other variables such as lower functioning, higher age, other psychosis diagnosis, and, to a lower extent, higher scores in cognitive, positive, and excitative symptoms, explained deficits of insight dimensions. These data could help to design gender-specific preventive and therapeutic strategies.

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1. Introduction

Lack of insight is a common feature in psychosis (Amador et al., 1991). Their negative effects have been related to a generally poor prognosis of schizophrenia, predisposing to non-adherence with antipsychotic medication (Drake et al., 2015; Sendt et al., 2015; Novick et al., 2015). In addition, lack of insight has been found to be predictive of higher relapse rates, increased number of involuntary hospital admissions, substance misuse, diminished psychosocial function, and a poorer course of illness (Amador and

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David, 2004; Lincoln et al., 2007; Mohamed et al., 2009; Quee et al., 2011; Wiffen et al., 2012; Ekinci and Ekinci, 2013). On the other hand, there is also a small positive relationship between clinical insight (Mintz et al., 2003) and cognitive insight (Palmer et al., 2015) and depressive symptoms in schizophrenia. In addition, there is a debate suggesting that insight may represent a risk factor for suicide in patients with schizophrenia (López-Moríñigo et al., 2012; López-Moríñigo et al., 2014).

Insight is a multidimensional phenomenon that includes awareness of having a mental disease, of the effects of medication, of the social consequences of the disease, of specific signs and symptoms, and attribution of symptoms to the disorder (Amador et al., 1994; Amador and David, 2004; David et al., 2012). Awareness of symptoms is the ability to recognize that a particular experience is strange or unusual, whereas the attribution of symptoms requires the capacity to interpret this experience as a symptom related to the disease (Amador and David, 2004).

Great efforts have been made in order to understand the mechanisms of action of this complex phenomenon. Several studies have examined the relationship between insight and positive, negative, and global psychotic symptoms, as well as depression (David et al., 1992; Amador et al., 1994; Kemp et al., 1995; Collins et al., 1997; Kim et al., 1997; Mohamed et al., 1999; Moore et al., 1999). A statistically significant weak negative relationship has been consistently reported between insight and positive, negative, and global psychotic symptoms. With regard to depressive symptoms, there seems to be a positive relationship with insight (Mintz et al., 2003). Lack of insight, moreover, has been related with neuropsychological impairment, metacognition, and Theory of Mind (Aleman et al., 2006; Pousa et al., 2008). The relationship with sociodemographic variables is controversial (Amador et al., 1994; Ayesa-Arriola et al., 2011; Wiffen et al., 2012).

Schizophrenia and first-episode psychosis are disorders with considerable heterogeneity in several of its basic features. There is great variability in clinical presentation, disease course and response to both pharmacological and psychosocial treatment. Some aspects of this heterogeneity may be gender related and gender differences have been studied extensively in recent decades. Although there are definite findings, much uncertainty remains about the extent of the differences (Riecher-Rössler et al., 1994; Riecher-Rössler and Häfner, 2000; Abel et al., 2010; Ochoa et al., 2011). The incidence of schizophrenia is higher in men, and most studies also find an earlier age of onset in men. In relation to possible gender differences in clinical symptoms, it has been suggested that men suffer more negative symptoms. In contrast, women suffer more affective symptoms. Premorbid functioning and outcome social functioning seem to be better in women. Moreover, women have better remission and lower relapse rates (Ochoa et al., 2011). Gender differences in cognitive functioning in psychosis remain an issue, with lack of consensus in the gender-related neuropsychological profile (Moriarty et al., 2001; Ochoa et al., 2011; Ayesa-Arriola et al., 2014; Rodriguez-Jimenez et al., 2015; Hui et al., 2014; Ittig et al., 2015).

Little is known about the role of gender in the deficit of insight in psychosis. A careful review of the previous literature was carried out and there was a lack of studies specifically devoted to the issue. However, there were some previous studies that included gender aspects of insight as collateral results or examined the role of gender as a secondary analysis. All these dispersed data are next reviewed. In the original article of Amador et al. (1994), insight (assessed with the abbreviated version of the Scale to Assess Unawareness of Mental Disorders, SUMD) was unrelated to gender, age, or educational level. Moriarty et al. (2001) did not find differences in item G12 (lack of judgment/insight) of the Positive and Negative Syndrome Scale (PANSS). McEvoy et al. (2006) prospectively studied young patients with a first episode of psychosis using the Insight and Treatment Attitudes Questionnaire, and showed a better insight into the psychotic illness for women. In the prospective study of Parellada et al. (2011), insight was evaluated in first episode early-onset schizophrenia and other psychosis using the SUMD: women correctly attributed psychotic symptoms to the disorder, whereas men attributed symptoms to other causes. Using the extended version of SUMD, Pruß et al. (2012) reported that both stigma and gender were strong predictors of insight, with a better insight in women. However, Parellada et al. (2009), Ayesa-Arriola et al. (2011), also using the SUMD, did not observe gender differences in first episode psychosis. Mutsatsa et al. (2006) using the Schedule for the Assessment of Insight did not find significant gender differences in insight in first episode psychosis. Wiffen et al. (2012), using the Schedule for the Assessment of Insight-Expanded version, found no evidence of significant gender differences in adult symptomatically stable psychotic patients. These contradictory findings may be related to differences in the study populations as well as the use of different instruments to assess insight and other related variables. In addition, previous studies have tended to use relatively small sample sizes and have studied gender differences in global insight measures or dimensions. There is a lack of studies focused on insight into specific psychotic symptoms.

Therefore, this study was designed with two objectives: a) to assess gender differences in the deficit of insight in patients with schizophrenia and other psychosis, considering both general insight dimensions as well as insight into specific symptoms; and b) to assess the differential effect of clinical, sociodemographic, and functional variables in the deficit of insight in men and women.

Some outcome variables such as better remission and lower relapse rates, a better social function, and a clinical profile with a greater weight of affective symptoms (Ochoa et al., 2011) suggest that women with a psychotic disorder may present a greater awareness of the disorder than men. Exploring gender differences on insight in a multidimensional way could offer a better understanding of the process, especially about the complexity of the interaction between biologic and sociodemographic and cultural aspects. In addition, therapeutic approaches could benefit from the results of the analysis.

Thus, the relationship between insight and gender in psychosis remains unclear, although a better understanding of the impact of gender on this crucial aspect of the disease may be of value to target more effective interventions. On this basis, we established the hypotheses that men and women will show differences in the three main awareness dimensions of psychosis, and also that men and women will exhibit differences related to insight, in particular psychotic symptoms and their attribution. In addition, we hypothesize that the variables that explain deficit in awareness would differ according to gender.

2. Methods

This was a cross-sectional multicenter study of patients with schizophrenia and other psychotic disorders, attended between 2006 and 2011 in daily clinical practice, aimed at exploring the descriptive characteristics of insight in a large sample of patients at different stages of the illness and in different clinical settings in the area of Barcelona.

2.1. Participants

The study sample included 401 patients with schizophrenia and other psychotic disorders attended in four Mental Health Departments of the metropolitan Area of Barcelona (Catalonia), which constituted the "*Insight Barcelona Research Group*" (Institute

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