



# The development of insight and its relationship with suicidality over one year follow-up in patients with first episode psychosis



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## ABSTRACT

**Objective:** Insight into psychosis has been linked to suicidality, although inconsistently. The co-variation between insight and suicidality over time is under-investigated. The aim of the present study was to investigate predictors of suicidality in patients with first episode of psychosis (FEP) over one year, focusing on the relationship between insight and suicidality.

**Methods:** Patients with FEP ( $n = 146$ ) were interviewed as soon as possible after treatment starts and at one year follow-up.

**Results:** At baseline 37% of patients were suicidal, significantly reduced to 20% at follow-up. The effect of insight on suicidality was in different directions at different time-points, with insight at baseline increasing and insight at follow-up decreasing the risk of suicidality at follow-up. Patients with stable levels of insight across baseline and follow-up did not differ in risk for suicidality at follow-up. However, patients who lost insight from baseline to follow-up were more often suicidal at follow-up, whilst patients who gained insight were more seldom suicidal at follow-up. Other predictors of suicidality at follow-up were more depressive episodes before study entry, longer duration of untreated psychosis, more suicide attempts six months prior to follow-up, and depression at follow-up.

**Conclusion:** The results indicate that the effect of insight on suicidality in FEP-patients depends on time of assessment and of changes in insight. Gaining insight during treatment was associated with reduced risk for suicidality, whilst losing insight had the opposite effect, underlining the need to monitor insight over time and tailor interventions according to illness phase.

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## 1. Introduction

Suicidal behaviour is prevalent in psychotic disorders. Approximately 5% of patients with schizophrenia kill themselves (Palmer et al., 2005), and as many as 50% of patients have suicidal thoughts or attempt suicide (Bolton et al., 2007). Studies show that suicidal behaviour occurs both before treatment starts and after treatment has commenced (Barrett et al., 2010a; Bertelsen et al., 2007). Hence, identifying and treating suicidal symptoms are a major target in clinical practise.

Insight into psychosis has been defined as the awareness of having a mental disorder, its symptoms, and need for treatment (David,

1990). Poor insight is a common feature of schizophrenia (Amador and Gorman, 1998), associated with poor treatment adherence (Lincoln et al., 2007) and thus a potential obstacle to recovery. High insight is associated with lower symptom levels (Mintz et al., 2003), better social function (Olfson et al., 2006) and work performance (Lysaker et al., 2002), but also with more depression (Mintz et al., 2003) and hopelessness (Carroll et al., 2004). There are findings of an inconsistent link between insight and suicidality. Some studies find that higher insight is related to increased suicidality (Barrett et al., 2010a; Foley et al., 2008; Robinson et al., 2009), others to decreased suicidality (Bourgeois et al., 2004; Steblaj et al., 1999) and some studies find no relationship (Barrett et al., 2010a; Hawton et al., 2005; Restifo et al., 2009). Taken together, this indicates that there are different profiles between insight and distress.

Both suicidality and insight fluctuate over time (Tarrier et al., 2006; Wiffen et al., 2010). The level of one of these phenomena

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here-and-now might not be related to historical levels – or predict future levels – of the other. In line with this, we have previously shown that insight measured at study entry in FEP patients was significantly associated with the *concurrent* level of suicidality (Barrett et al., 2010b) but not with *previous* suicidal behaviour i.e. prior to study entry (Barrett et al., 2010a), indicating the importance of measuring insight and suicidality at the same time-point. The aim of the present study was thus to investigate predictors of suicidality in an expanded sample of FEP-patients, particularly focusing on the development of insight over one year follow-up and its relationship with suicidality.

## 2. Materials and methods

### 2.1. Participants

The present study included patients from the Thematically Organized Psychosis (TOP) study in Oslo, Norway. The patients were recruited consecutively from inpatient and outpatient psychiatric units from October 2002 until February 2011 from major hospitals in Oslo, Norway covering a catchment area of approximately 485,000 inhabitants. Inclusion criteria were as follows: age: 18–65 years and a first episode of a psychotic disorder according to the DSM-IV (American Psychiatric Association, 1994) (schizophrenia, schizoaffective disorder, schizophreniform disorder constituting “Schizophrenia spectrum disorders and delusional disorder, brief psychosis, and psychosis NOS constituting “Other psychotic disorders”). Patients could be included into the study until 52 weeks after the start of adequate treatment but were not considered FEP-patients if they had previously been treated with antipsychotic medication in adequate dosage for more than 12 weeks or until remission. Other exclusion criteria were history of severe head injury, brain damage, neurological disorder, and mental retardation. All participants signed written informed consent. The study was approved by the Regional Committee for Medical Research Ethics and the Norwegian Data Inspectorate. Of 207 patients participating at baseline, 146 agreed to meet for follow-up assessment. All patients who did not meet for follow-up were still alive (National Population Register data). There were no statistically significant baseline differences in demographical or clinical variables between patients who participated and those who did not participate at follow-up (data not shown).

### 2.2. Assessments

The patients were interviewed as soon as possible after treatment starts (baseline) and again after 12 months (follow-up) by trained psychologists or psychiatrists. Diagnoses were set using the Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I) (First et al., 1995). Age at onset was defined as age at first SCID-verified psychotic symptom. Suicide attempts and depressive episodes were recorded in the SCID-I interview and cross-checked with hospital records for 1) the period up until study entry (baseline) and 2) during six months prior to follow-up. Psychotic episodes during six months prior to follow-up were recorded based on the SCID interview. Hospital admissions during six months prior to follow-up were recorded based on patient information and hospital records.

Current suicidality was assessed at baseline and follow-up by item 8 on the Calgary Depression Scale for Schizophrenia (CDSS) (Addington et al., 1990). Symptoms during the past two weeks (ideation, attempts) were rated on a scale from 0 to 3, with higher scores indicating more severe symptoms. A CDSS suicidality score of 0 was labelled “Non-suicidal” and scores of 1–3 were labelled “Suicidal”. Six patients lacked scores for CDSS suicidality. Their scores on the “Suicidal thoughts” item on the Inventory of Depressive Symptoms – Clinician Rated (IDS-C) (Rush et al., 1996) were transformed into corresponding CDSS scores.

Severity of positive and negative symptoms for the last week was assessed with the Structured Interview for Positive and Negative Syndrome Scale (SCI-PANSS) (Kay et al., 1987) (PANSS positive and negative subscales). Duration of untreated psychosis (DUP) was measured as weeks from psychosis onset (score of  $\geq 4$  on PANSS items P1, P3, P5, P6, or G9 for >one week) until the start of adequate treatment. Patients were categorised as either “Psychotic at both points in time” or “Not psychotic at both points in time” based on baseline and follow-up scores of these items. Current depression was measured by the PANSS item G6. Insight into illness was measured by the PANSS item G12 (lack of judgement and insight). G12 scores at both time-points were reversed and dichotomised into “No insight” (scores 1–2) and “Insight” (scores  $\geq 3$ ). This was then used as the basis for the variable “Change of insight”, with patients categorised as either having “No insight at both time points”, “Insight at both time points”, “Loss in insight” or “Gain in insight” from baseline to follow-up.

Premorbid functioning was assessed with the Premorbid Adjustment Scale (PAS) (Cannon-Spoor et al., 1982) and divided into two domains: Academic and Social, with childhood scores and scores of premorbid change calculated for both (Haahr et al., 2008). Current functioning was assessed with Global Assessment of Functioning (GAF-F, split version) (Pedersen et al., 2007). Information about alcohol and substance use during the six months prior to study entry and during six months prior to follow-up was obtained from a detailed interview and hospital records. Reliability for central measures was good; for more information see Faerden et al. (2010).

### 2.3. Statistical analysis

Analyses were performed with IBM SPSS Statistics 21. Parametric analyses were used for normally distributed variables and non-parametric analyses for variables with skewed distributions. Categorical variables were analysed with chi-square and McNemar tests, and continuous variables were analysed with Student t-tests and Mann-Whitney U tests. Analyses were two-tailed with a pre-set level of significance of .05. To investigate predictors, a series of binary logistic regression analyses were conducted with “Being non-suicidal versus suicidal at follow-up” as the dependent variable. Clinical and demographical variables that differed significantly between the two groups were entered into the regression analyses in three blocks (background, baseline, and follow-up variables respectively). Scores of premorbid functioning (PAS) were reversed for the regression analysis to facilitate interpretation (i.e. high scores indicate better functioning). Due to skewed distribution DUP was log-transformed ( $\ln \text{DUP} + 1$ ) and the following variables were dichotomised: depressive episodes, suicide attempts, hospital admissions (all into no incident = 0,  $\geq 1$  incident(s) = 1), and PANSS depression (item G6) (scores 1 and 2 = 0, scores  $\geq 3$  = 1) for the regression analyses. Independent variables were removed from subsequent analyses if they did not have a statistically significant contribution. In a final model, the interaction between Insight (baseline)  $\times$  Insight (follow-up) was entered in a fourth block.

## 3. Results

Differences in background and baseline variables in patients with suicidality and in those without suicidality at one year follow-up are shown in Table 1. Twenty-nine patients (20%) were suicidal at follow-up compared to 54 (37%) at baseline, a statistically significant reduction ( $p < .001$ ). Nineteen patients (13%) were suicidal at both points in time. Patients who were suicidal at follow-up had significantly poorer premorbid childhood social and academic functioning, longer DUP, and more depressive episodes and suicide attempts before study entry, compared to non-suicidal patients. Suicidal patients at follow-up also had significantly higher baseline PANSS depression and had a higher degree PANSS insight compared to non-suicidal patients. They also had significantly more depressive episodes, suicide attempts and

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