Schizophrenia Research 159 (2014) 527–532

Contents lists available at ScienceDirect

Schizophrenia Research

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

Impact of interpersonal factors on insight in schizophrenia

Tastet Hélène [a], Verdoux Hélène [b,c], Bouisson Jean [a], Destaillats Jean-Marc [d], Prouteau Antoinette [a,d,*]

[a] EA 4139, Univ Bordeaux, 3 ter Place de la Victoire, F-33000 Bordeaux, France
[b] Univ Bordeaux, 146 rue Léo Saignat, F-33000 Bordeaux, France
[c] INSERM U657, 146 rue Léo Saignat, F-33000 Bordeaux, France
[d] Department of Adult Psychiatry, Jonzac Hospital, Domaine des Fossés, F-17500 St Martial de Vitaterne, France

ARTICLE INFO

Article history:
Received 20 January 2014
Received in revised form 25 July 2014
Accepted 6 August 2014
Available online 16 September 2014

Keywords:
Insight
Interpersonal factors
Schizophrenia
Therapeutic alliance
Social support
Social cognition

ABSTRACT

Whereas clinical insight in schizophrenia has been consistently associated with personal factors (i.e. sociodemographic characteristics, symptoms or cognition), little is known about its relationships with interpersonal factors (i.e. close environment and personal characteristics involved in social interactions). Most of the few studies available have focused on one particular interpersonal factor, such as social cognition, contact frequencies or therapeutic alliance. To date, no study has explored the specificity of associations between clinical insight and different levels of interpersonal factors, neither if these associations are independent of personal factors.
Associations between insight and interpersonal factors were explored through multiple regression in a sample of 80 outpatients with schizophrenia spectrum disorders. Lower insight was associated with lower interpersonal functioning, independently from personal factors such as age, gender, age at first hospitalization, executive functioning and symptoms. Our findings replicate previous studies with regard to the associations between clinician-rated insight and social cognition or social contact frequencies. They also provide new information about specific associations between clinician-rated insight and perceived social support as well as between patient-rated insight and therapeutic alliance. Finally, models of insight based on personal factors were significantly improved by the inclusion of interpersonal factors. These results strongly support the crucial role of interpersonal factors in insight, both from the clinician's and the patient's point of view. These exploratory data require further replication.

© 2014 Elsevier B.V. All rights reserved.

1. Introduction

Clinical insight is defined as the awareness of presenting with a mental disorder in a multidimensional perspective (e.g. awareness of illness, symptoms, consequences, need of treatment etc.) (Amador and David, 1998; David and Kemp, 1998; Saravanan et al., 2005). Studies focusing on schizophrenia patients most often consider insight as a phenomenon depending on the patient's ability to be aware of and to judge correctly his/her experience. Accordingly, predictors of insight have been extensively investigated in terms of personal factors such as symptoms or cognition (Cooke et al., 2005; Dam, 2006; Shad et al., 2006; Osatuke et al., 2008; Chakraborty and Basu, 2010). Meta-analyses have reported significant yet modest associations between insight and psychotic symptoms (Mintz et al., 2003). Similarly, the effect sizes of the associations between insight and general cognitive functioning are small, except for executive functioning (Aleman et al., 2006). However, contradictory findings have been obtained concerning the association between insight and personal factors (Cooke et al., 2005; Dam, 2006; Shad et al., 2006; Osatuke et al., 2008; Chakraborty and Basu, 2010). This raises the question of additional factors that could further explain such discrepancies. Some authors have argued that that insight presents with a "contractual nature" and is the result of a "construction" between the patient and the clinician (Tranulis et al., 2008). Indeed, recent studies provided evidence that the awareness of illness is not just a possession of a singular fact such as "I have symptom X" or "I need treatment Y" (Marks et al., 2000), but is an inextricable part of a personal narrative that may be incoherent or incomplete for many different narrative reasons (Lysaker et al., 2002). When it comes to constructing a narrative of one's illness, there are structural aspects of that narrative construction that are related to cognition (Lysaker et al., 2005) and others that are related to interaction with others (e.g., peers, family members, or professionals) (Roe et al., 2010). In this sense, it is not just co-constructed with clinicians but with others as well (e.g. family members who think that the patient is symptomatic). Hence, it may be of interest to consider such interactive processes when assessing insight, as measures may be influenced by interpersonal factors (Markova, 2005).

* Corresponding author at: Department of Psychology, Univ Bordeaux, 3 ter Place de la Victoire, 33076 Bordeaux cedex, France. Tel.: +33 5 57 57 19 64; fax: +33 5 57 57 19 76.
E-mail addresses: htastet@ch-perrens.fr (T. Hélène), helene.verdoux@u-bordeaux2.fr (V. Hélène), jean.bouisson@u-bordeaux2.fr (B. Jean), jm.destaillats@ch-jonzac.fr (D. Jean-Marc), antoinette.prouteau@u-bordeaux2.fr (P. Antoinette).

http://dx.doi.org/10.1016/j.schres.2014.08.009
0920-9964/© 2014 Elsevier B.V. All rights reserved.

According to Howard et al. (2008), interpersonal factors refer to the closest environment of a person and are defined as "interactions with family, friends, coworkers and peers that serve as role models or are part of the provision of emotional, social, and/or instrumental support". This model of interpersonal factors is derived from the conception of person–environment interaction by Fougeyrollas (Fougeyrollas, 1997; Fougeyrollas et al., 2002). In this model, interpersonal factor is an interactionist concept that refers to the "theory of systems". There are intrinsic personal factors, extrinsic environmental factors and their interaction from which result interpersonal relationships or social functions (Fougeyrollas, 1997; Fougeyrollas et al., 2002). Interpersonal factors can thus be measured through the following distinct levels: i) a person's abilities specifically involved in social interactions (e.g. social cognition); ii) the characteristics of the close environment (e.g. social support, therapeutic alliance, self-stigma); and iii) the interaction between a person and his/her close environment during an interview (e.g. therapeutic alliance, both patient- and clinician-rated).

Only a few recent studies have explored the associations between insight and interpersonal factors in schizophrenia. Insight level has been positively associated with social cognition independently from neurocognition (Bora et al., 2007; Langdon and Ward, 2009; Konstantakopoulos et al., 2014; Quee et al., 2014). These personal abilities, which involve synthetic metacognitive operations (see Kukla et al., 2013; Lysaker et al., 2013), are a condition for high functioning in a complex interpersonal world (Lysaker et al., 2011) or to highly self-perceived recovery in the domain describing reliance on others (Kukla et al., 2013). With respect to characteristics of the close environment, one study showed that awareness of illness was weakly associated with several dimensions of the social network: positively with the number of close friends, primary group size, frequency of contacts with friends and family, having both close friends and close family members; and negatively with satisfaction regarding contact with friends (White et al., 2000). Another study found that a better therapeutic alliance (clinician- and patient-rated) was associated with higher insight (Barrowclough et al., 2010). Studies also found associations between insight and social functioning (Lysaker et al., 1998, 2007) or related variables, which include a person's capacity for social relations and the breadth of social relations (Francis and Penn, 2001) and interpersonal relationships (Lysaker et al., 1998). Taken together, these results suggest that several dimensions of interpersonal factors may play a role in insight level. However, more studies are needed to extend these results and to jointly explore the impact of interpersonal and personal factors on insight. Considering the contractual nature of insight, there are several reasons to expect relationships with interpersonal factors. Indeed, a less coherent account of one's schizophrenia might be more difficult for other persons to join and help the patient. Also, with fewer connections with others, there is less opportunity to borrow their perspective when thinking about oneself (White et al., 2000; Barrowclough et al., 2010).

The present exploratory study had the following objectives: to identify the interpersonal factors associated with patient-rated and clinician-rated insight in schizophrenia independently from personal factors (socio-demographic characteristics, symptoms, and cognition); and to explore the additional predictive power of interpersonal factors on models of insight initially including personal factors only.

Table 1
Patient-rated and clinician-rated insight scores.

	N	Mean (SD)	Min–max
SUMD total (1–5)	54	6.54 (3.12)	3–15
Unawareness of mental disorder		1.98 (1.14)	1–5
Unawareness of achieved effects of medication		2.22 (1.28)	1–5
Unawareness of social consequences		2.33 (1.35)	1–5
Unawareness of symptoms (items 4–20)		2.35 (0.96)	1–5
IS total (0–16)	78	11.41 (3.61)	0–16
Awareness of symptoms		2.60 (1.31)	0–4
Awareness of illness		2.04 (1.26)	0–4
Awareness of need of treatment		3.3 (1.13)	0–4

N, number; SD, standard deviation; min, minimum; max, maximum; SUMD, Scale to assess Unawareness of Mental Disorder; IS, Insight Scale.

Table 2
Good vs poor insight frequency according to insight measures.

Insight	Scale	Poor	Good
Illness	SUMD	39.6%	60.4%
	IS	73.6%	26.4%
Medication	SUMD	43.4%	56.6%
	IS	11.3%	88.7%
Symptoms	SUMD	26.4%	73.6%
	IS	35.8%	64.2%
Consequences	SUMD	49.1%	50.9%
Total	SUMD	39.6%	60.4%
	IS	17%	83%

SUMD, Scale to assess Unawareness of Mental Disorder; IS, Insight Scale.

2. Methods

2.1. Participants

Outpatients with schizophrenia spectrum disorders ($n = 80$) were recruited in a rehabilitation unit of a rural sector ($n = 37$) and in an urban sector of adult psychiatry ($n = 43$). Participants were consecutively included before regular psychiatric consultation from January 2010 until February 2011 if they fulfilled the following criteria: 1) fluent in French; 2) written informed consent prior to participation; 3) diagnosis of schizophrenia or schizoaffective disorder according to DSM-IV-TR criteria (APA, 1994); 4) medication and clinical status stable for at least one month; 5) no history of neurological disease or brain injury; and 6) no substance dependence according the DSM-IV criteria (APA, 1994). Subjects did not receive any monetary incentive for their participation. The investigation conformed to the French bioethics and clinical research legislation and all participants provided written informed consent to participate.

2.2. Assessment

2.2.1. Insight

Insight was assessed with the Insight Scale (IS, Birchwood et al., 1994), a patient-rated insight scale. The sum of three subscale scores (awareness of symptom, awareness of illness, awareness of need of treatment) yields the total IS score ranging from 0 to 12, with low scores indicating poor insight. The full version of the Scale to assess Unawareness of Mental Disorder (SUMD, Amador et al., 1993) was used as a clinician-rated insight scale. The full version of the SUMD distinguishes current and retrospective insight. Only current insight was considered in the present study. In order to increase the reliability of measurement, individual scores from the first three SUMD items (awareness of mental disorder, awareness of the achieved effects of medication, awareness of the social consequences of mental disorder) were summed to create a total SUMD score (Marks et al., 2000). Additionally, the 17 items specifically measuring symptoms were summed and divided by the number of appropriate items to create a SUMD unawareness of symptoms score. The IS and the SUMD were administered in a counterbalanced order. Of note, the total IS score and the total SUMD score did not exactly include the same sub-dimensions.

2.2.2. Personal factors

Age at onset was defined as age at first hospitalization. With respect to cognition, we used the Modified Card Sorting Test (MCST, Nelson, 1976; Godefroy and GREFEX, 2008), as executive functioning has been consistently associated with insight (Aleman et al., 2006). Number of

Download English Version:

https://daneshyari.com/en/article/6824851

Download Persian Version:

https://daneshyari.com/article/6824851

Daneshyari.com