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The longitudinal course of cognitive insight and mood in bipolar disorder

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ABSTRACT

Cognitive insight or the ability to be self-reflective and to retain from being over-confident in own beliefs is an upcoming topic in research regarding psychiatric disorders. In bipolar disorder investigations are scarce and an important lacuna is the unexamined longitudinal relationship between cognitive insight and mood. Therefore, in this study the level of cognitive insight, mania and depression were assessed in a total of 56 patients with bipolar disorder at baseline, four months and eight months follow-up. In addition, the cognitive insight of 35 healthy controls was assessed at baseline and at four months follow-up. The current research shows that self-reflectiveness and self-certainty remained stable over time in bipolar disorder. The improvement of mood did not affect the course of cognitive insight. However, at baseline higher levels of depression were correlated with more self-reflectiveness. In addition, self-reflectiveness was higher for bipolar disorder patients in comparison with the healthy controls. Our results could imply that higher levels of self-reflectiveness are a specific characteristic in bipolar disorder that is independent from an improvement in mood.

1. Introduction

In bipolar disorder the lack of insight into the illness is a well-described phenomenon (Varga et al., 2006). Insight encompasses the awareness of having a disorder, compliance to treatment and the attribution of the symptoms to the illness (David, 1990). This clinical insight is sometimes seen as too narrow a concept as it does not necessarily entail a complete understanding of the illness and its consequences (Beck et al., 2004). Because of this, the concept of cognitive insight, or the ability to be self-reflective and to retain from being overconfident, was developed by Beck et al. (2004). Self-reflectiveness concerns the capacity to reflect on our experiences. The second element, self-certainty involves dysfunctional decision-making, such as "overconfidence in one's judgements" and "jumping to conclusions". In schizophrenia it seems that patients who have higher self-reflectiveness and lower self-certainty (i.e. higher cognitive insight) display less positive symptomatology (Beck et al., 2004; Lysaker et al., 2010). Carse and Langdon (2013) found that delusion proneness goes together with higher levels of both self-certainty and self-reflectiveness. Importantly, the latter correlation decreased after correction for rumination. This suggests that self-reflectiveness could share similarities with rumination, which is typical for depressive thinking (David et al., 2012). This notion has been confirmed in schizophrenia and schizoaffective disorder where a positive correlation between self-reflectiveness and depression is found (Palmer et al., 2015). A more fine-grained knowledge on cognitive insight and its relationship with clinical variables such as mood is of great significance because previous research indicates that higher cognitive insight is associated with better functional outcome (O'Connor et al., 2013).

Although cognitive insight is subject to a growing body of research in numerous illnesses other than schizophrenia (for review, see Van Camp et al., 2017), research in bipolar disorder is scarce. While there is some research on cognitive insight in bipolar disorder in general (Caletti et al., 2017; Engh et al., 2007; Van Camp et al., 2016; Zhang et al., 2015), the relationship between mood, symptoms and cognitive insight in bipolar disorder has only been investigated once. In this study, cognitive insight was assessed in non-symptomatic patients. It found that cognitive insight was higher for patients whose most recent episode had been depression compared to those who most recently had had a manic episode (Colis et al., 2006). An important shortage of previous research regarding mood and cognitive insight in bipolar disorder is the inclusion of only euthymic patients at time of assessment. In addition, the longitudinal course of cognitive insight in bipolar disorder has never been examined. The former information would

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contribute to the further understanding of cognitive insight in bipolar disorder. The current study is the first longitudinal investigation of cognitive insight in patients with bipolar disorder during mood episodes. It examines if cognitive insight changes over time and it investigates the relationship between cognitive insight, depression and mania.

2. Methods

2.1. Participants

Inpatients ($N = 41$) were recruited in three psychiatric centres in the region of Antwerp, Belgium. Additionally, outpatients ($N = 15$) were recruited via the Flemish patient association Ups and Downs.[2] The inclusion criteria were: age between 18–65 years, DSM-IV-TR diagnosis of bipolar disorder type I or II (American Psychiatric Association, 2000) and suffering from an acute mood episode (depressive, (hypo)manic or mixed episode). Age and gender matched healthy controls ($N = 35$) were recruited mainly among the staff of the participating centres. All subjects participated in a broader research project on bipolar disorder and inflammation for which following exclusion criteria were established: substance abuse, use of anti-inflammatory drugs, autoimmune diseases, chronic inflammatory or neurological diseases, mental retardation, pregnancy or breastfeeding, electroconvulsive therapy in the past 6 months, and significant disturbances on a standard screening blood test. In the control group, the following additional exclusion criteria were applied: current or past diagnosis of major depressive disorder, bipolar disorder or psychotic syndrome as defined by DSM-IV-TR criteria (American Psychiatric Association, 2000) and bipolar disorder or psychotic syndrome in a first-degree family member.

The study was approved by the Committee for Medical Ethics of the University Hospital Antwerp and the Antwerp University and the local ethical committees of the participating centres.

2.2. Study design

The first test day took place within 1–5 days after screening (moment 1). For patients, two subsequent test days took place after four (moment 2) and eight months (moment 3), respectively. During the study period inpatients received treatment as usual that included psychopharmacological treatment and psychological follow-up (a weekly conversation with a psychologist in order to assess the symptomatology of the patients). Seventy-two percent of the inpatients received an additional psychotherapeutical programme during hospitalization. This additional treatment consisted of a weekly psycho-education session where patients received information about their diagnosis and how it is treated. Second, the Metacognitive Training (Moritz and Woodward, 2007) was held weekly. Also, a session that focused on compensatory strategies (such as, how to deal with an impaired attention-span or memory) was provided once a week. In addition, patients attended training once a week that focused on their personal experiences with bipolar disorder. Lastly, cognitive remediation training was offered twice a week for 50 min (CogPack, version 6; Marker Software). To evaluate the natural evolution of cognitive insight between different time points, healthy controls were assessed at baseline (moment 1) and after four months (moment 2).

2.3. Beck cognitive insight scale

For the assessment of cognitive insight, the Beck Cognitive Insight Scale (BCIS; Beck et al., 2004) was administered. The BCIS is a 15-item self-report instrument consisting of two subscales: self-reflectiveness and self-certainty and a composite index. Research of Engh et al. (2007) demonstrated that the BCIS has an acceptable internal consistency for patients with bipolar disorder (alpha self-reflectiveness 0.73 and alpha self-certainty 0.61) and healthy controls (alpha self-reflectiveness 0.73 and alpha self-certainty 0.63).

2.4. Clinical assessments

The M.I.N.I.-plus, International Neuropsychiatric Interview (Sheehan et al., 1998) was used as diagnostic instrument in patients and controls. In patients, the severity of mood symptoms was assessed by the Hamilton Depression Rating Scaling (HDRS; Hamilton, 1960) and the Young Mania Rating Scale (YMRS; Young et al., 1978). At screening, threshold score for inclusion was set at ≥ 17 for the HDRS-17 or ≥ 13 for the YMRS, corresponding to moderate depression or hypomania respectively (Vieta, 2011; Zimmerman et al., 2013). On subsequent test days, the mood state of patients was classified as 'depressive', '(hypo) manic', 'mixed' or 'euthymic' according to the HDRS and YMRS scores and clinical assessment of the investigator. To evaluate the presence of positive psychotic symptoms, the positive subscale of the Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987) was administered on test days. All clinical evaluations were performed by a psychologist and a psychiatrist in training. For all participants, medication use and the occurrence of any exclusion criteria was assessed on both test days.

2.5. Statistical analysis

Baseline differences in clinical and demographic characteristics between patients and healthy controls were examined by two-tailed independent *t*-tests for continuous variables and Pearson chi-square test for categorical variables. Longitudinal data were examined using linear mixed model analysis with the BCIS scores as outcome variable. The relation between severity of mood symptomatology and BCIS scores was studied by Spearman. All statistical analyses were performed in JMP Pro 12 (SAS Institute Inc., 2015).

3. Results

The baseline characteristics of the healthy controls and the patients are shown in Table 1. Regardless time point or mood state, no difference was found between patients and healthy controls for the self-certainty subscale and the composite index. Patients had a significantly higher score on the self-reflectiveness subscale in comparison with the controls. However, when patients were grouped by mood states (depression vs. (hypo)mania vs. mixed episode vs. euthymia), only patients in the depressive group had a significantly higher score on the self-reflectiveness subscale in comparison with healthy controls ($F(174.2) = 2.6$; $p = 0.040$). No significant differences in the self-certainty subscale and composite index were found between specific mood states in patients and healthy controls.

As displayed in Table 2, we did not observe a significant change in BCIS subscales over time in both patients and controls. There was a significant decrease in HDRS and YMRS scores over time in the patient group. This improvement had no effect on the course of cognitive insight.

Spearman correlations revealed that in the patient group at baseline, scores on the HDRS correlated positively with scores on the self-reflectiveness subscale ($N = 56$, $r = 0.291$, $p = 0.026$). When patients were divided into depressed and non-depressed based on their mood states at entry, the correlation at baseline failed to reach significance ($N = 31$, $r = 0.300$, $p = 0.129$; $N = 25$, $r = 0.123$, $p = 0.509$, respectively). There was no correlation between the mood scales and the BCIS at the four or eight month's follow-up.

Because of the heterogeneity in the patient group, we performed several post-hoc tests. No significant differences in BCIS scores were found between inpatients and outpatients, between patients that followed psychotherapeutic group sessions and patients that did not

[2] https://www.upsendowns.be/.

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