Relation Between Insight and Quality of Life in Patients With Schizophrenia: Role of Internalized Stigma and Depression

Ehab Sayed Ramadan and Wessam Abdou El Dod

[1]Assistant professor of Psychiatry Neuropsychiatry Departement, Tanta Faculty of Medicine, [2]Acting Head of Consulting Department Qatar Foundation For Child And Woman Protection.

ABSTRACT

Introduction: Schizophrenia was held up as the epitome of a disorder with lack of insight. Higher levels of insight have been shown to correspond to better psychosocial functioning and clinical outcomes. The focus on patients' subjective sense of wellbeing is a fairly new phenomenon.

Aim of the Study: Is to throw light on the impact of unawareness of mental illness on the quality of life (QOL) in patients with schizophrenia and also the role of internalized stigma and depression in this respect.

Subjects and Methods: Scale of Unawareness of Mental Disorder (SUMD) was applied to each schizophrenic patient recruited and then 2 groups of schizophrenic patients (30 patients each) were established; Group I was meant to have higher scores while group II was meant to have lower scores in the SUMD. Patients of both groups were subjected to Schizophrenia Quality of Life Scale (SQOLS), Internalized Stigma of Mental Illness Scale (ISMI) and Hamilton Depression Rating Scale (HDRS).

Results: Patients with poorer insight showed significantly lower scores of ISMI and HDRS and higher scores in aspect QOL than those with better insight.

Conclusion: This means that when QOL is linked to patient awareness of his mental illness, it is thus a complex issue. QOL of schizophrenic patients may be undermined through the effect of internalized stigma and feeling of hopelessness and depression proved in those patients with good insight.

Abbreviations: QOL Quality Of Life, SQOLS Schizophrenia Quality Of Life Scale, SUMD Scale Of Unawareness Of Mental Disorder, IMSI Internalized Stigma of Mental Illness, HDRS Hamilton Depression Rating Scale.

Key words: Schizophrenia, depression, insight, stigma, quality of life.

Current Psychiatry; Vol. 17, No. 3, 2010: 43-48

INTRODUCTION

Traditionally, psychotic symptoms and lack of insight were considered to be two sides of the same coin, or the phenomena were supposed to underlie each other (a rather circular relationship). Furthermore, schizophrenia was held up as the epitome of a disorder with lack of insight26. Indeed, impairment of insight was the most common and discriminating symptom for schizophrenia in the World Health Organization's International Pilot Study of Schizophrenia30. More recent work using more complex definitions of insight2 found that lack of insight was common in schizophrenia (and psychotic bipolar disorder), but less so in other affective and schizoaffective disorders diagnosed as part of the DSM-IV field trials.

Insight is defined as the ability to recognize that one has a mental illness or is experiencing psychopathological symptoms8. Although insight is a relevant focus of intervention for people with a range of mental illnesses, most research in the area has focused on its relevance to schizophrenia11. Higher levels of insight have been shown to correspond to better psychosocial functioning and clinical outcomes1. Although a great deal of research has addressed lack of insight, little information is available to guide clinicians in working with clients who have impaired insight. Studies that link insight to severity of symptoms offer hope that treating the symptoms will improve insight2. However, more information is needed to develop psychosocial interventions in this area. It has been suggested that identity, quality of life (QOL) and a sense of control are instrumental in shaping the explanatory models that people develop to understand the experience of mental illness29.

There has been much interest in the specificity of insight for certain specific features of mental disorder such as positive, negative symptoms, mood disorder and abnormal perceptions and there are now a number of psychometric instruments and scales to assess insight26. It should be emphasized, however, that there is correspondence between most scales in covering such aspects as acceptance of the illness 'label' and perceived need for treatment4,23. Depending on their particular aims, clinicians or researchers

can now choose the appropriate tool from the instruments available. A single-item insight assessment of the traditional mental state examination provides the investigator with little information about the quality or quantity of insight which may be of interest in epidemiological studies, or in everyday psychiatric practice. The appearance of 'poor insight', 'good insight' or even 'partial insight' in psychiatric case notes should be a thing of the past. Comment needs to make as to which aspects of the whole presentation of the therapist's formulation the patient accepts. Does this varies from moment to moment or as the illness evolves? How fixed is it? Does illness awareness lead inevitably to treatment adherence, or is there no connection? Do the patient's actions indicate some awareness of their illness as opposed to their overt statements? Detailed longitudinal monitoring in clinical settings and psychopathology research requires more structured measurement of insight26.

The study of QOL and the focus on patients' subjective sense of wellbeing is a fairly new phenomenon that has attracted professional attention only within the past two decades. Issues of life quality become key when cure is impossible. Illness that can not be eliminated must be managed and the treatment goal becomes maintaining maximum function and a meaningful existence12. While interest has grown steadily in understanding how persons with schizophrenia appraise their disorder and subsequent needs, the nature of the impact of awareness or admission of the disorder on various domains of QOL has remained a matter of considerable debate9. It has been alternatively held that acknowledgment of one's mental illness is a detriment and a key to successful adaptation. From one perspective, acceptance of illness has been advanced as a key to making informed decisions about one's future, to free oneself from blame for difficulties linked with illness and to forming bonds with others who are aware of one's difficulties. From another view however, "awareness of illness" has been suggested to represent the acceptance of a system of social power in which one's individuality and dignity is at risk of being diminished. Indeed both awareness and lack of awareness have significant risks associated with them18.

Stigma associated with mental illness is universal. It leads to rejection, discrimination, distress and other burdens and is a major obstacle to the rehabilitation and reintegration of people with mental illness. Stigma can also lead, via anticipated and actual discrimination and internalized stigma, to decreased life satisfaction and self-esteem, increased alcohol use, depression17 and suicidality10. Research on the stigma of persons with mental illness has differentiated between public stigma and self-stigma. Self-stigma refers to the internalization of stigmatizing ideas and the reaction of those affected by a mental disorder22 and has received far less attention in current research. Essentially, the development of self-stigma is related to the process by which persons with mental disorders stigmatize themselves. However, it is unclear why some people with mental illness remain relatively unaffected by stigma, whereas others perceive stigma as more stressful and are demoralized, with often serious clinical consequences and more impact on QOL. Indeed, a little is known about the vulnerability to stigma and the extent to which stigma is experienced..

SUBJECTS AND METHODS

Schizophrenic patients participated were collected from the Neuropsychiatry Department and also from Center of Psychiatry, Neurology and Neurosurgery (Tanta University, Cairo, Egypt). They were diagnosed according to the DSM-IV criteria5. Those included were schizophrenic patients who passed the acute stage and already assigned to a rehabilitation program. They are either inpatient or outpatients. History of substance abuse/dependence, presence of organic brain disorder, absence of a reliable attendance or lack of informed consent were all exclusion criteria.

Patients were then submitted to the Scale of Unawareness of Mental Disorder (SUMD). Accordingly, they were classified into 2 groups:

Group I: Those who were proved to have poor awareness of their mental illness both clinically and by SUMD scale (30 patients)

Group II: Those who were proved to have good awareness of their mental illness (30 patients)

SUMD scale: This scale1 attempts to measure specific and global aspect of awareness and also assess patient attributions about the cause of different signs and symptoms. It represents a comprehensive and detailed approach to insight. The scale has 20 items which are 3 general items (awareness of having mental disorder, awareness of the achieved effect of medication and awareness of the social consequences of mental disorder) and 2 subscale items consisting awareness and attribution of specific signs and symptoms (17 items). Scale rating range from 1 – 5 with higher scores indicating poorer awareness or attribution.

Both groups were subjected to the following psychometric tests:

Schizophrenia Quality of Life Scale (SQOLS): This scale28 compromises 30 statements to be answered on 5 points Liker scale type. The scale was subdivided into 3 subscales addressing different dimensions about impact of schizophrenia on QOL including psychosocial functioning, motivation and energy and symptoms and side effects of medications.

Internalized Stigma of Mental Illness (ISMI) Scale: This scale21 (29 items), was designed to measure the subjective experience of stigma with sub-scales measuring alienation (6 items), stereotype endorsement (7 items), perceived discrimination (5 items), stigma resistance (5 items) and social withdrawal (6 items). The items are rated on a 4-point Likert-type scale, ranging from strongly disagree to strongly agree. The stigma resistance items also serve as a validity check because they are reverse-coded. The total ISMI score ranges between 4 and 91. High scores in ISMI indicate that

internalized stigmatization is more severe in the individual

Hamilton depression rating scale of depression (HDRS-17)13: for measuring depression severity in schizophrenic patients.

Statistical methods: Data collected was introduced to personal computer and statistical analysis was done using EPIS and SPSS program. Statistical significance was accepted at the $p<0.05$ level. All values were expressed as means and standard deviations.

RESULTS

Table 1: Demographic data of the study groups.

	Group I (30 patients)		Group II (30 patients)	
Age	Range	20 – 43		21 – 40
	Mean	32.5 (2.4)	Mean	30.5 (2.2)
Sex				
Males		19		23
Females		11		7
Duration of illness	Mean	9.4 (2.7)	Mean	9.2 (2.5)

Table 2: SUMD mean scores (Item I, II and III) in both groups of schizophrenic patients.

	Item I		Item II		Item III	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Group (I)	4.00	0.74	4.00	0.74	3.2	0.89
Group (II)	1.67	0.55	1.37	0.49	1.17	0.38
t	12.85		15.63		11.20	
p	0.000		0.000		0.000	

Group (I) patients are having significantly higher score of SUMD scale than group (II) i.e. Significantly poorer insight is described in group (I) than in group (II)

Table 3: SQOLS mean scores in both groups of schizophrenic patients.

	SQOLS scores	
	Mean	**SD**
Group (I)	70.2	6.1
Group (II)	33.5	4.6
t	22.1	
p	0.000	

Group (I) patients are having significantly higher scores of SQOLS than group (II) i.e. significantly higher QOL reported by group (I) than group (II)

Table 4: ISMI mean scores in both groups of schizophrenic patients.

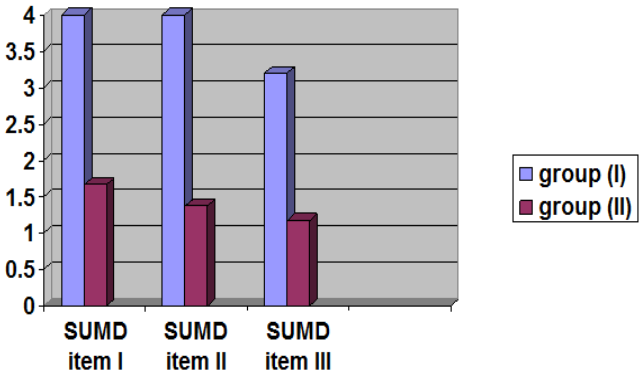
	ISMI scores	
	Mean	**SD**
Group (I)	24.57	8.3
Group (II)	77.23	12.29
t	-19.27	
p	0.000	

Group (I) patients are having significantly lower scores of ISMI than group (II) i.e. significantly lower internalized stigma of mental illness reported by group (I) than group (II)

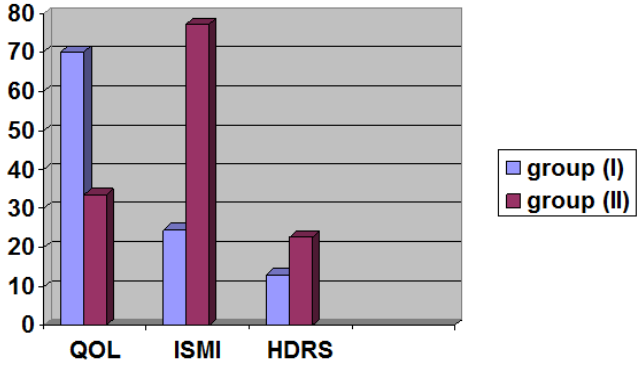
Table 5: HDRS mean scores in both groups of schizophrenic patients.

	HDRS scores	
	Mean	**SD**
Group (I)	13.00	5.7
Group (II)	22.77	6.31
t	- 7.51	
p	0.000	

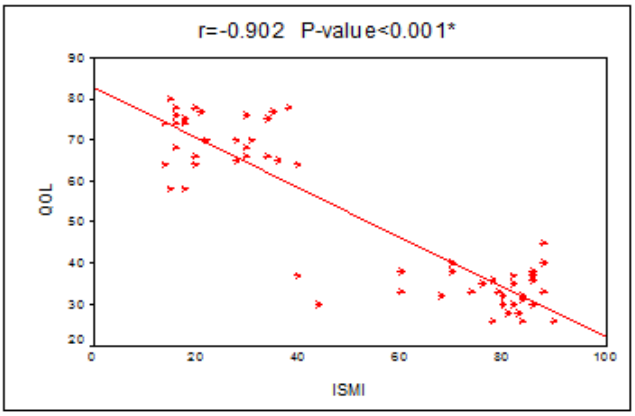
Group (I) patients are having significantly lower scores of HDRS than group (II) i.e. significantly lesser depression severity in group (I) than group (II)



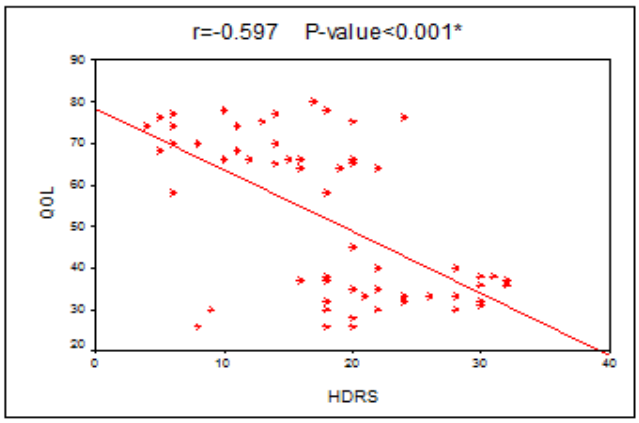
Graf 1: SUMD scores item I, II, III in both groups of schizophrenic patients.



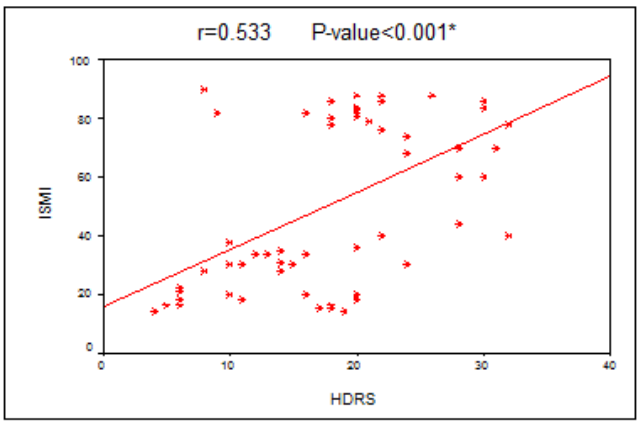
Graf 2: score of SQOLS, ISMI and HDRS in both groups of schizophrenic patients.



Graf 3: Correlation between SQOLS and ISMI scores (-ve).



Graf 4: Correlation between SCOLS and HDRS scores (-ve).



Graf 5: Correlation between HDRS and ISMI scores (+ve).

DISCUSSION

Here we throw the light on the impact of unawareness of mental illness on the QOL in schizophrenic patients. It was reported in different studies that there is a controversy in this respect16. In this study, schizophrenic patients with poorer insight (higher scores in the SUMD scale) showed significantly higher scores in the aspect QOL (SQOLS) (t=22.1, p=0.000).

In many other studies insight deficits have been associated with poor course of illness and noncompliance to treatment and a positive relations have been uncovered between a low frequency of social contacts, low levels of basic social skills, social isolation and small social networks and lack of insight19,25,27. However, other research has failed to uncover any relation between insight and measures of psychosocial well-being6,24, whereas some investigations have actually found insight to be related positively to such indicators of poor psychosocial adjustment as depression3 and low emotional well-being14.

Two approaches to resolve this controversy can be found in the literature on insight. In a recent review16 on the relation between insight into mental disorder and outcome, both of these approaches are presented as complementary accounts of the source of the controversy. Major assumptions of one of these accounts are that insight is positively related to treatment adherence and to self- and social stigmatization. Accordingly, because of its link to adherence, insight will produce symptom reduction and improved functioning while lowering self-esteem and increasing depression and helplessness due to its association with self- and social stigmatization.

In this study, a positive correlation was found between insight and internalized stigma of mental illness. Those with poorer insight tend to be less stigmatized by their illness i.e. an inverse relation between scores of SUMD and SQOLS and those of ISMI (t=19.27, p=0.000 r=0.902, p<0.001). Moreover, in this study, patients with poorer insight exhibit significantly less depression scores than those who retain a considerable portion of their insight i.e. an inverse relation between scores of SUMD and SQOLS and those of HDRS (t=-7.51, p=0.000, r=0.597, p=<0.001). A positive correlation was also found between scores of HDRS and ISMI (r=0.533, p<0.001).

This study's findings support the use of the term “usable insight” to denote insight that separates the symptoms of the disorder from reality and separates the disorder from identity while preserving hope. Thus, insight can be "usable" if it increases compliance with treatment and at the same time decreases the negative impact of stigmatization by separating the illness from one's identity. This kind of insight is also consistent with the concept of recovery16. An implication of the latter account is that certain forms of insight may reduce the hope of persons with schizophrenia and, thus, elicit negative responses to the illness. The present study tested the latter account of the inconsistent findings regarding the relation between insight and clinical, personal and social correlates of schizophrenia by examining the relations between insight into mental illness, depression and QOL.

Internalized stigmatization is the devaluation, shame, secrecy and withdrawal triggered by applying negative stereotypes to one's self7. Internalized stigmatization also has negative effects on coping with stigmatization within any given society. It is considered to be an easier target for therapeutic intervention in patients with schizophrenia31.

Schizophrenic patients who possess a considerable amount of their insight tend to realize their restrictions and their need for treatment. They become depressed especially with the regain of their emotions and internalization of the stigma of their illness. Stigma can also lead, via anticipated and actual discrimination and internalized stigma, to decreased life satisfaction and self-esteem, increased alcohol use, depression17 and suicidality10. However, it is unclear why some people with mental illness remain relatively unaffected by stigma, whereas others perceive stigma as more stressful and are demoralized, with often serious clinical consequences. Indeed, we know little about the vulnerability to stigma and the extent to which stigma is experienced. It has been suggested that identity, QOL and sense of control are instrumental in shaping the explanatory models that people develop to understand the experience of mental illness15. If these factors are relevant to insight, they could be targeted for psychosocial intervention.

According to this study it can be concluded that insight is a more complex entity than could be considered. Dealing with the schizophrenic patients in the acute and rehabilitation phase should address such issues like illness stigma with specially its internalized component, extent of hopelessness and depression and their role in determining patient's wellbeing. Therapeutic alliance in this respect should be tactfully designed.

More comprehensive studies are needed to cover the complex relation between insight and QOL in schizophrenia and also other major psychosis like bipolar disorder. Variables like demographic data, subtypes and severity of illness needs to be incorporated.

REFERENCES

1. Amador XF, Strauss DH, Yale SA, Flaum MM, Endicott J, and Gorman JM. Assessment of insight in psychosis. Am.J.Psychiatry 1993 Jun;150(6):873-9.
2. Amador XF, Flaum M, Andreasen NC, Strauss DH, Yale SA, Clark SC, et al. Awareness of illness in schizophrenia and schizoaffective and mood disorders. Arch.Gen.Psychiatry 1994 Oct;51(10):826-36.
3. Amador XF, Friedman JH, Kasapis C, Yale SA, Flaum M, and Gorman JM. Suicidal behavior in schizophrenia and its relationship to awareness of illness. Am.J.Psychiatry 1996 Sep;153(9):1185-8.
4. Amador XF and Seckinger RA. The assessment of insight: A methodological review. Psychiatr.Ann. 1997;27(12):798-805.
5. American Psychiatric Association. Diagnostic and Statistical Manual of mental disorders DSM-IV. 4th ed. Washington, DC: American Psychiatric Association; 1994.
6. Browne S, Garavan J, Gervin M, Roe M, Larkin C, and O'Callaghan E. Quality of life in schizophrenia: Insight and subjective response to neuroleptics. J.Nerv.Ment.Dis. 1998 Feb;186(2):74-8.
7. Corrigan PW and Watson AC. The paradox of self-stigma and mental illness. Clin.Psychol.Sci.Prac. 2002;9(1):35-53.
8. David AS. Insight and psychosis. Br.J.Psychiatry 1990 Jun;156:798-808.
9. Eack SM and Newhill CE. Psychiatric symptoms and quality of life in schizophrenia: A meta-analysis. Schizophr.Bull. 2007;33(5):1225-37.
10. Eagles JM, Carson DP, Begg A, and Naji SA. Suicide prevention: A study of patients' views. Br.J.Psychiatry 2003 Mar;182:261-5.
11. Nassir Ghaemi S. Insight and psychiatric disorders: A review of the literature, with a focus on its clinical relevance for bipolar disorder. Psychiatr.Ann. 1997;27(12):782-90.
12. Goodman M and Smith TE. Measuring quality of life in schizophrenia. Medsc.Ment.Health 1997;2:1-13.

Corresponding Author:

Dr. Ehab Sayed Ramadan
Institute of Psychiatry, Zagazig Uuniversity, Sharkia, Egypt.
0127552626
E-mail: Ehab_ramadan@yahoo.com

13. Hamilton M. Development of a rating scale for primary depressive illness. Br.J.Soc.Clin.Psychol. 1967 Dec;6(4):278-96.
14. Hasson Ohayon I, Kravetz S, Roe D, David AS, and Weiser M. Insight into psychosis and quality of life. Compr.Psychiatry 2006 Jul-Aug;47(4):265-9.
15. Kurs R, Farkas H, and Ritsner M. Quality of life and temperament factors in schizophrenia: Comparative study of patients, their siblings and controls. Qual.Life Res. 2005 Mar;14(2):433-40.
16. Lincoln TM, Lüllmann E, and Rief W. Correlates and long-term consequences of poor insight in patients with schizophrenia. A systematic review. Schizophr. Bull. 2007;33(6):1324-42.
17. Link BG, Struening EL, Neese Todd S, Asmussen S, and Phelan JC. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. Psychiatr.Serv. 2001 Dec;52(12):1621-6.
18. Ritsner MS, Awad AG. Insight and quality of life in schizophrenia spectrum disorders. In: Lysaker PH, Louanne D, editors. Quality of life impairment in schizophrenia, mood and anxiety disorders, New perspectives on research and treatment: Springer; 2007. p. 227-40.
19. Lysaker PH, Roe D, and Yanos PT. Toward understanding the insight paradox: Internalized stigma moderates the association between insight and social functioning, hope and self-esteem among people with schizophrenia spectrum disorders. Schizophr.Bull. 2007;33(1):192-9.
20. Packer S, Husted J, Cohen S, and Tomlinson G. Psychopathology and quality of life in schizophrenia. J.Psychiatry Neurosci. 1997 Jul;22(4):231-4.
21. Ritsher JB, Otilingam PG, and Grajales M. Internalized stigma of mental illness: Psychometric properties of a new measure. Psychiatry Res. 2003 Nov 1;121(1):31-49.
22. Rusch N, Angermeyer MC, and Corrigan PW. Mental illness stigma: Concepts, consequences and initiatives to reduce stigma. Eur.Psychiatry 2005 Dec;20(8):529-39.
23. Sanz M, Constable G, Lopez Ibor I, Kemp R, and David AS. A comparative study of insight scales and their relationship to psychopathological and clinical variables. Psychol.Med. 1998 Mar;28(2):437-46.
24. Simon AE, Berger GE, Giacomini V, Ferrero F, and Mohr S. Insight in relation to psychosocial adjustment in schizophrenia. J.Nerv.Ment.Dis. 2004 Jun;192(6):442-5.
25. Smith TE, Hull JW, Goodman M, Hedayat-Harris A, Willson DF, Israel LM, et al. The relative influences of symptoms, insight and neurocognition on social adjustment in schizophrenia and schizoaffective disorder. J.Nerv.Ment. Dis. 1999;187(2):102-8.
26. Surguladze S and David A. Insight and major mental illness: An update for clinicians. Adv.Psychiatr.Treat. 1999;5:163-70.
27. White R, Bebbington P, Pearson J, Johnson S, and Ellis D. The social context of insight in schizophrenia. Soc.Psychiatry Psychiatr.Epidemiol. 2000 Nov;35(11):500-7.
28. Wilkinson G, Hesdon B, Wild D, Cookson R, Farina C, Sharma V, et al. Self-report quality of life measure for people with schizophrenia: The SQLS. Br.J.Psychiatry 2000 Jul;177:42-6.
29. Williams CC and Collins AA. Defining new frameworks for psychosocial intervention. Psychiatry 1999 Spring;62(1):61-78.
30. World Health Organization (WHO). Report of the international pilot study of schizophrenia. 1973. World Health Organization (WHO), Geneva.
31. Wright ER, Gronfein WP, and Owens TJ. Deinstitutionalization, social rejection and the self-esteem of former mental patients. J.Health Soc.Behav. 2000 Mar;41(1):68-90.