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Insight and subjective quality of life in people with schizophrenia

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Summary: *Many factors are likely to influence the subjective assessment of quality of life by people with schizophrenia. Among clinical factors, emotional disturbance and depression are most frequently reported to have a major negative influence on subjective quality of life, while positive or negative clinical manifestations have little impact on this measure. These subjective manifestations have a significant impact on the non-observance of care strategies and probably on the emergence of depressive disorders or suicidal ideation; the relationship between akathisia and suicide is for example widely documented in the literature.*
Improvement of cognitive functions is often associated with better autonomy in daily life. The awareness of the disorders and the improvement of cognitive functioning cannot totally exclude the risk of deterioration in the subjective quality of life of patients and potentially the appearance of depressive disorders.

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I. Introduction:

The treatment programs for people suffering from schizophrenia justify evaluations based on both objective measures (number of relapses, objective symptoms, etc.) and subjective measures (quality of life, etc.). In schizophrenia, many indicators have been used to assess quality of life. The majority of them are hetero-questionnaires constructed from the point of view of experts. Low insight and / or cognitive impairment are the two limiting factors for the majority of authors to the self-assessment of quality of life in schizophrenia. (10)

II. Notion of Insight:

Insight comes from the German "Einsicht" which in French can mean inspection, examination, knowledge, common sense, judgment (Marková, 2009). It is interesting to note that insight in French remains associated with awareness of the disease, but is not restricted to it. (9) Insight is a complex phenomenon, interesting on several dimensions, and which has to do with the perception and awareness of one's own disorder (6) we have witnessed for a dozen years a renewed interest in awareness of the disorder , in particular in Anglo-Saxon studies which resort to the concepts of insight, awareness, attribution ... Amador, in 1993, gave for awareness the following definition: "recognition of the signs and symptoms of the disease, whereas the attribution relates to the explanations concerning the origin or the cause of these signs or symptoms ". Awareness is considered synonymous and interchangeable with insight.
It is a pragmatic approach, as close as possible to the clinic, with an attempt to quantitatively assess the consciousness of the disorder in patients. (6)
The clinical model of Amador et al. (5) - (4): Scale to Assess Unwareness of Illness in Mental Disorders (SUMD)
The model of Amador et al is currently considered the benchmark model in clinical and research to understand the concept of insight in schizophrenia and in psychotic disorders in general. These authors have proposed a continuous and multidimensional approach to insight where two main dimensions are considered:
awareness of the symptomatology of the disease and the process of attributing symptoms. Awareness disorder is defined by these authors as a lack of agreement between the judgment that the subject makes on his condition and that which is issued by the practitioner.
This awareness concerns four dimensions which are as follows:
• mental disorder; the effects of treatment; the social consequences of the disease;

• specific signs and symptoms (for example, hallucinations, emotional dullness, etc.). The lack of attribution of symptoms refers to the fact that the patient does not consider a mental disorder as being at the origin of these. In their model, these authors also considered a temporal dimension by dichotomizing the insight of the current symptomatology from that relating to the past history of the disease. Insight is therefore defined in this case as a phenomenon that can evolve over time. Based on this model, these authors proposed an instrument for measuring insight (3): the Scale to Assess Unwareness of Illness in Mental Disorders. Widely standardized in its original English-speaking version, this scale is used in a privileged way in clinical and research. It consists of a

semi-structured interview which assesses the degree of insight, present and past. SUMD is organized around four dimensions, each referring to the different levels of consciousness previously specified and the presence of 17 specific signs and symptoms of schizophrenia. For each of these symptoms, the clinician assesses whether or not the patient attributes their origin (for example, mental illness or demonic possession). SUMD is not the only scale for assessing the degree of insight in schizophrenia. Table 1 provides a summary of all the other tools currently available and validated. They consist of either a self- or hetero-evaluation. The number of items that compose them is extremely variable and few of them have been validated in French.

III. Concept of subjective quality of life

By definition, subjective quality of life (QoL-S) refers to a subject's satisfaction with his own life (Lehman, 1983). Indeed, "the perception that an individual has of his place in existence, in the context of the culture and the system of values in which he lives, in relation to his objectives, expectations, standards and concerns" is an integral part of his well-being. As a measure of subjective well-being, QoL-S is therefore a major factor in mental health, whether mental or physical, and represents an important dimension of psycho-social functioning, (9)

Assessment of subjective quality of life

QoL-S can be assessed using the Lancashire Quality of Life Profile (LQOLP) (Oliver et al, 1997), translated and validated in French (Salomé et al, 2004). The LQOLP contains 94 items in 9 areas of life: work, leisure, religion, finance, lifestyle, law and security, family relations, social relations, health. (9)

IV. Insight and schizophrenia:

The prevalence of insight disorders is high, since 50 to 80% of patients suffering from schizophrenia have a lack of insight (Amador and Gorman, 1998). (9)

Many factors are likely to influence the subjective assessment of quality of life by people with schizophrenia. Among clinical factors, emotional disturbances and depression are most frequently reported as having a major negative influence on subjective quality of life, while positive or negative clinical manifestations have little impact on this measure (1), (2).

The severity of the disease most often has a negative influence on the subjective quality of life; influence largely related to the existence of a depressive disorder. It therefore appears possible, if we want to improve the quality of life of people suffering from schizophrenia, to put in place preventive and / or curative strategies vis-à-vis the emergence of depression in the course of the evolution of troubles.

A confounding factor with emotional disturbances is the existence of psychic extrapyramidal manifestations (dysphoria) linked to neuroleptic treatments. We have been able to show that the subjective quality of life of patients suffering from schizophrenia is negatively correlated with the subjective neurological manifestations of neuroleptics, and not with the objective manifestations [10]. This observation implies taking systematic account of the subjective manifestations linked to the psychotropic drugs prescribed in the clinic.

These subjective manifestations have a significant impact on the non-observance of care strategies and probably on the emergence of depressive disorders or suicidal ideation; the relationship between akathisia and suicide is for example widely documented in the literature. It is thus advisable to systematically take into account, in the adaptation of care, from the point of view of the patient (subjective!) Concomitantly with the usual objective evaluations. (10)

The question of insight in schizophrenic disorders and its role in the development of disorders is widely debated (2). Insight is a multidimensional concept referring to concepts as diverse as that of recognizing the disorder, recognizing the need for care, or even taking symptoms into account. Like quality of life, insight has been evaluated in a very heterogeneous way in schizophrenia, reflecting the conceptual differences surrounding this notion (10). The relationships between insight and quality of life are widely studied in the literature, the results being most often contradictory, ranging from a negative relationship between quality of life and insight to the notion that non-awareness of the disease would be associated with an overestimation of the quality of life. These discrepancies can be explained by the use of instruments measuring both quality of life and various insights based on different conceptual points of view. (10)

Patients with a higher awareness of schizophrenic disorder feel less empowered, less independent, less free to act and make decisions than those with a lower level of consciousness. This result can be interpreted as the fact that a low level of awareness of the disease can be a "defense strategy" in the face of the stigma and disabilities associated with the diagnosis of schizophrenia. This defense strategy probably avoids depressive decompensation. (10)

We can also admit that the understanding of oneself and one's illness is shared with the consciousness of others, which could also suggest that people who are more aware of their illness are also those who assess the most acutely support from those around them and their families. (10)

Strategies to improve insight in patients should be used with caution by regularly assessing the onset of a mood disorder and / or suicidal ideation that awareness of the disease may precipitate. (10)

V. The potential consequences of a high insight:

A-Adherence to treatments: Adherence to drug treatments is one of the objectives of the care of patients suffering from psychotic disorders. We currently have effective drug treatments which allow a reduction or even disappearance of symptoms, an improvement in psychosocial functioning, and a reduction in the frequency of relapses.) The poor compliance concerns a third of schizophrenics during initial hospitalization, half of schizophrenics 1 year later initial hospitalization and two-thirds or three-quarters 2 years after initial hospitalization. Weiden and Olfson estimate that poor adherence to treatment is responsible for 40% of relapses occurring in the year following hospitalization and establishment of a treatment. A review of 24 studies shows that schizophrenic patients treated with antipsychotics take an average of 58% of the prescribed doses. (8) The factors influencing good therapeutic adherence in schizophrenia would seem to be the following:

• perception of severity; the level of support; family stability; the positive therapeutic alliance; the role of psychoeducation; the dosage form - mode of administration. Whereas on the contrary, the decrease in compliance would be influenced by:

• rejection of the disease; lack of insight; adverse effects; poor control of symptoms; a complex prescription; substance abuse; inadequate therapeutic combination; insufficient communication; lack of investment from loved ones. (6)

B. Suicide and depression

: The link between insight and suicidal behavior has been the subject of numerous studies. Some report a positive relationship between insight and suicidal behavior or ideation (Robinson et al, 2009; Schennach-Wolff et al, 2009; Gonzalez, 2008; Harvey et al, 2008; Crumlish et al, 2005; Evren & Evren, 2004; Schwartz & Smith, 2004) while others find no significant association (Barrett et al, 2010; Robinson et al, 2010; Bakst et al, 2010; Restifo et al, 2009; Bourgeois et al, 2004; Kim et al, 2003; Yen et al, 2002; Amador et al, 1996; Hu et al, 1991). It cannot currently be affirmed that there is a link between the level of insight at a time T1 and the passage to the suicidal act at a time T2 (López-Moríñigo et al, 2012). However, it is possible that certain dimensions of insight (insight toward the need for treatment, insight toward mental illness) are associated with an increased risk of suicidal behavior, while others are not (Schwartz & Smith, 2004; Dantas & Banzato, 2007). It is important to note that moderating variables - such as loss of hope (Wilson & Amador, 2007; Carroll et al, 2004; Kim et al, 2003) or the level of depression (Crumlish et al, 2005) explain the relationship sometimes obtained between high insight and suicide attempt (for review, see Pompili et al, 2004). (9) most cross-sectional studies have failed to establish cause and effect relationships between depression and insight (Lincoln et al, 2007). It also appears that these relationships vary over time and are more stable during the first psychotic episodes (Mutsatsa et al, 2006; Mintz et al, 2004; Sim et al, 2004). For some, it would be a transitional stage, during which the awareness of suffering from schizophrenia would naturally be accompanied by a rise in the level of depression, linked to this phase of acceptance of a new status (Wittmann & Keshavan, 2007; Wittmann et al, 2010). (9)

VI. Conclusion:

In conclusion, the consideration of subjective quality of life in the evaluation of care programs for people suffering from schizophrenia must be associated with objective measures. Current programs aim to improve cognitive functioning through cognitive remediation programs. Improvement of cognitive functions is often associated with better autonomy in daily life. Another important aspect of these programs is the improvement of insight which is supposed to increase adherence to care and reduce the risk of relapse of patients. However, the impact of these rehabilitation programs on the subjective quality of life should be taken into account. The awareness of the disorders and the improvement of cognitive functioning cannot totally exclude the risk of deterioration in the subjective quality of life of patients and potentially the appearance of depressive disorders. (10)

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