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Original Research Article

Comparative Study of the Degree of Insight in Patients with Schizophrenia and Bipolar Affective Disorder

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Abstract

Background and Objectives: Poor insight in psychosis has been described as a lack of awareness of having an illness, of the deficits caused by the illness, the consequences of the disorder, and the need for treatment. Evidence suggests that poor insight is a manifestation of the illness itself, rather than a coping strategy. This symptom predisposes the individual to noncompliance with treatment and has been found to be predictive of an increased number of involuntary hospital admissions, poorer psychosocial functioning, and a poorer course of illness. The objective of the current study is to evaluate and compare the degree of insight in patients with schizophrenia and bipolar affective disorder mania during their hospitalisation.

Methods: Sixty patients, 30 each belonged to the schizophrenia and bipolar affective disorder mania group respectively. The diagnosis was made according to the ICD-10 classification of mental and behavioural disorders, Diagnostic Criteria for Research [DCR -10]. The various socio demographic and clinical variables between the two groups were compared.

Conclusion: Our study showed that there was a significant improvement in insight during hospitalisation in both schizophrenia and mania groups. The mania group had a significantly higher improvement in insight than the schizophrenia group.

Keywords: Schizophrenia, Mania, Bipolar Affective Disorder.

Introduction

Impaired awareness of illness has been known for hundreds of years. In 1604 in his play, "The Honest Whore", Thomas Dekker has a character say: "That proves you mad because you know it not". Among neurologists, unawareness of illness is well known since it also occurs in some individuals with stroke, brain tumors, Alzheimer's disease and Huntington's disease [1]. The term “anosognosia” was first used by a French neurologist in 1914 The Oxford English Dictionary defines Insight as "an inner sight, a discernment, a wisdom (or) glimpse of you beneath the surface”. To put it simply, it means the capacity to understand the hidden truth. Insight, as a concept of a symptom, got introduced during the later part of the 19th century by Dagonet [2].

In 1934, Aubrey Lewis provided a temporary definition of Insight: “a correct attitude to morbid change in oneself”, but warned that the words ‘correct’, ‘attitude’, ‘morbid’ and ‘change’ each called for

discussion. He also said, "All questions of the judgment of reality, such as…. the consideration of insight, go to the root of the psychopathology of different conditions [3]

The usage of the word by Gestalt psychologists for an "aha" experience and the psychoanalytic classification into 'emotional' and 'intellectual' is avoided here .Our study is restricted to the usage of the word for recognizing one's own mental disorder, medication effects, social consequences, awareness and attribution of signs and symptoms.

Material and Method

The study was conducted in the department of Psychiatry, Anugrah Narayan Magadh Medical College and Hospital Gaya. Bihar. All inpatients admitted in the family psychiatry wards of the department of psychiatry during the study period constituted the population for the study.

The study sample consists of 2 groups . A consecutive method of sampling with 30 consecutive patients who satisfied the ICD-10 DCR criteria for schizophrenia were compared with 30 consecutive patients who satisfied the ICD-10 DCR criteria for bipolar affective disorder- current episode mania. Both groups must satisfy the inclusion and exclusion criteria

Inclusion criteria

- Inpatients.
- Male and female patients.
- Age group between 18 to 65 years.
- Patients diagnosed with schizophrenia using ICD-1O DCR criteria.
- Patients diagnosed with bipolar affective disorder mania using ICD-1O DCRcriteria

Exclusion criteria

- Patients with co- morbid medical or neurological disorders.
- Substance use (except nicotine).
- Schizoaffective disorder.
- Depressive episode.

The study has been cleared by the institutional ethical committee. A written informed consent was obtained from all the participants of the study belonging to either of the groups. Patients satisfying the inclusion and exclusion criteria were taken for the study. Psychiatric diagnosis of Schizophrenia and BPAD – Mania was made as per ICD – 10 Classification of mental and behavioral disorders, Diagnostic Criteria for Researsch (DCR-10). Consecutively selected 30 inpatients for each of the two groups , schizophrenia and mania were taken for the study. The socio demographic and clinical data were recorded in a specific profoma prepared for the study. The psychopathology, insight and functioning of the patients were assessed both at time of admission to the ward as well as at the time of discharge from the ward using the BPRS, SUMD and the GAF Scales respectively. The data from both the groups were then compared and studied.

The proforma was used to collect data such as name, age, sex, outpatient and inpatient numbers, marital status, employment status, details of occupation, religion, education, socioeconomic status, type of family and handedness. Clinical data that were recorded include the duration of illness (for schizophrenia) and number of episodes (for mania), details of prior treatment and details of current treatment. The BPRS is appropriate for evaluating baseline psychopathology, clinical outcome and treatment response with the frequency of repeat administrations at the discretion of clinical investigator. The scale was developed primarily for inpatient populations, but it may also be utilized for outpatients. A reliability co-efficient of 0.56 to 0.67 has been reported by authors.

Results

Table 1: Age Distribution

Age Group	Schizophrenia	Mania	Total
18 – 25 YRS	8 (26.7 %)	7 (23.3 %)	15 (25%)
26- 35 YRS	14 (46.7 %)	14 (46.7%)	28(46.7%)
36 – 45 YRS	5 (16.7 %)	3(10%)	8 (13.3%)
46 – 60 YRS	3(10%)	6(20%)	9(15%)

Out of the 30 patients in each group 46.7% of patients in both the groups were between 26-35 yrs of age., 26.7% of patients in schizophrenia group & 23.3% of patients in the mania group were between 18-25yrs of age,16.7% and 10% of patients belonging to schizophrenia and mania respectively fell between 36-45 yrs of age and the remaining 10% and 20% respectively belonged to 46-60yrs age group.

Table 2: Sex Distribution

Sex	Schizophrenia	Mania	Total
Females	12(40%)	11(36.6%)	23(38.3%)
Males	18(60%)	19(63.3%)	37(61.7%)

In the schizophrenia group 60% of the sample were males and 40% females, whereas in the mania group 63.3% were males and 36.6 % females. This gender difference however was not statistically significant.

Table 3 : Data on duration of illness in schizophrenia group

	Duration of Illness			
	< 2yrs	2-6 yrs	6-12yrs	>12yrs
Schizophrenia Patients	5(16.7%)	14(46.7%)	6(20%)	5(16.7%)

Out of the 30 patients 46.7% of schizophrenia group had a duration of illness from 2-6 yrs, 20% from 6-12yrs and 16.7% >12yrs and another 16.7% had < 2 yrs of illness.

Table 4: Data on number of episodes in mania group

	Number of Episodes		
	< 5	5 – 10	> 10
Mania Patients	19(63.3%)	8(26.7%)	3(10%)

Out of the 30 BPAD – Mania patients 63.3% had totally < 5 manic episodes,26.7% had between 5- 10 episodes and 10% had more than 10 episodes in the past.

Table 5: Changes in BPRS and GAF during hospitalization in BPAD – MANIA

BPAD - Mania	Admission		Discharge		Z value	P value
	Mean	S.D.	Mean	S.D.		
BPRS Score	43.40	4.53	23.03	1.650	4.79	0.001
GAF Score	35.67	3.467	65.87	2.300	4.79	0.001

Both in schizophrenia and in mania there was a statistically significant reduction in BPRS and improvement in GAF at discharge compared with at admission, when analyzed using the t-test.

Table 6: Correlation between severity of psychotic symptoms and unawareness at admission in Schizophrenia*:*

Unawareness of(SUMD item)	Mental disorder (1c)	Medication efficacy (2c)	Consequences (3c)
Correlation withBPRS	0.29	0.30	0.186
p	0.119	0.105	0.336

No significant correlation was found between unawareness and BPRS in theschizophrenia group at time of admission

Table 7: Correlation between severity of psychotic symptoms and unawareness at discharge in Mania

Unawareness of (SUMD item)	Mental Disorder(1c)	Medication efficacy(2c)	Consequences (3c)
Correlation withBPRS	-0.046	-0.282	-0.221
p	0.80	0.13	0.24

No significant correlation was found between unawareness and BPRS in the BPAD Mania group at time of discharge. No significant correlation was found between the duration of illness and unawareness in patients with schizophrenia at admission. However, a significant positivecorrelation was found between the duration of illness and unawareness of social consequences of mental disorder, that is more the duration of illness more the unawareness of consequences of mental disorder at time of discharge.

Discussion

It was found that 86% of schizophrenia patients and 100% of mania patients were unaware of their mental disorder at the time of admission (SUMD item 1c 2c & 3c). The literature data of the prevalence of unawareness of illness ranges from 50% to80% in various studies. The prevalence of unawareness in this study also falls within this range It was noted that although 86% of schizophrenia patients were unaware of mental disorder, only 76% were unaware of medication effects [4], and 83% were unaware of social consequences. This means that a person may be unaware of mental disorder but still be aware of medication effects and social consequences [5]. It is also noted that although 86% of schizophrenia patients were unaware of current mental disorder at the time of admission, only 66% were unaware of past mental disorder [6]. In other words, there are some patients who are unaware of current mental disorder but still aware of a past mental disorder. In mania, it was found that 100% were unaware of mental disorder, medication effects and of social consequences at the time of admission. One reason could be that all patients were seen in acute manic phase at time of admission. The mean insight score during hospitalisation was compared and significant differenceswere noted between the 2 groups, namely, mania and schizophrenia in the first 6 items of SUMD, where the mania group had significant improvement of insight than schizophrenia group [8]. This study has findings similar to other studies, which have shown schizophrenia to have a poorer insight compared to mania *e.g*., a study done by Pini, S in 2004 showed that schizophrenia subjects were much more compromised in insight dimensions than psychotic mania. Studies done by Fennig et al., (1996) Insight in schizophrenia and mania at admission versus discharge**:** Comparison of insight scores at admission with insight scores at discharge showed that insight at discharge was significantly better compared to insight at admission both in schizophrenia and mania [9]. In other words there was an improvement in insight during hospital stay and treatment. Studies suggest that approximately one-third of individuals with schizophrenia improve in awareness of their illness when they take antipsychotic medication. Studies also suggest that a larger percentage of individuals with bipolar disorder improve on medication. Insight in schizophrenia and mania at admission versus discharge Comparison of insight scores at admission with insight scores at discharge showed that insight at discharge was significantly

better compared to insight at admissionboth in schizophrenia and mania. In other words there was an improvement in insight during hospital stay and treatment. Studies suggest that approximately one-third of individuals with schizophrenia improve in awareness of their illness when they take antipsychotic medication. Studies also suggest that a larger percentage of individuals with bipolar disorder improve on medication. David [10], (1995), showed that 46% of the hospitalised psychotic patients showed improvement in insight during treatment. In this study also, patients had better insight at discharge as compared that at admission. My findings are consistent with a meta-analysis done by Ghaemi et al [7]., (2004), which showed that insight in mania showed improvement after recovering from acute mania. In other words, insight improves in bipolar mood disorder with resolution of the acute manic episode. This suggests that insight in mania is state dependent [11]. They too concluded that some aspects of insight are state related during exacerbation of illness in patients with schizophrenia and mania [12]. Correlation between insight and severity of psychotic symptoms at admission & discharge in mania In mania, both at admission and at discharge, no significant correlation between unawareness and psychotic severity was found in this study [13]. Correlation between insight and global functioning at admission and discharge in schizophrenia No significant correlation between insight and global functioning was found at the time of admission in schizophrenia patients Insight and duration of schizophrenia.

A significant negative correlation was found between number of episodes and unawareness of mental disorder in patients with mania at time of discharge, that is more the number of manic episodes less the unawareness of mental disorder [14,15].

Conclusions

To conclude our study showed that there was a significant improvement in insight during hospitalisation in both schizophrenia and mania groups . The mania group had a significantly higher improvement in insight than the schizophrenia group.

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