

A Comparative study of insight in patients of depressive spectrum disorders attending outpatient department of tertiary care centre.

Manish Kumar Goyal¹, Alok Tyagi², Richa Jain³, Gunjan Solanki⁴

¹Department of Psychiatry, JLN Medical College, Ajmer, India.

^{2,3,4} Department of psychiatry, SMS Medical College, Jaipur, India.

Abstract

Introduction: Poor insight is a common feature of bipolar depression and unipolar depression with and without psychotic symptoms (PS) which may lead to poor clinical outcome. Studies on insight in these populations are relatively limited and the majority of studies were published over the previous decade.

Methods: This was a cross-sectional, observation study conducted in Psychiatry O.P.D. of tertiary care hospital. The sample consisted cohort of 20 outpatients each with unipolar depression, unipolar depression with psychotic symptoms and bipolar disorder current episode depression with psychotic symptoms. The depression was assessed by HAM-D and insight by Item G12 of the General Psychopathology section of PANSS.

Results: Significant difference in insight is seen in all three groups. Bipolar patients with PS had the poorest insight, patients with unipolar depression had best. Statistically significant correlation is present with older age and lack of insight among patients of unipolar depression with PS ($\rho = .599$, $P = .005$) and bipolar depression with PS ($\rho = .686$, $P = .001$).

Conclusion: Insight in depressive illness is affected by multiple factors; this study shows that age, bipolarity and presence of psychotic symptoms are associated with poor insight. Management of the patients of depressive spectrum should incorporate strategies to improve insight

Key words: Insight, Bipolar depression, Unipolar depression

Introduction

Insight is an inner sight, discernment, wisdom, or a glimpse of you beneath the surface (Oxford English dictionary). However, it may undergo marked change when terms in ordinary language are adopted in technical vocabulary. In psychiatry, insight is a significant human capacity for mental 'seeing' what is going on below the surface and also in the minds of others people about us. It is a multidimensional phenomenon that requires both inner and outer orientation. It involves our capacities for introspection, empathy and communication^[1]. Recent conceptualization of insight is that it is both a continuum as well as dimensional^[2,3] and there is now some consensus among researchers about the components of insight. David explained three dimensions for insight: awareness of illness, awareness of symptoms, and the perceived need for

treatment.^[4]

Poor insight is an important construct in psychotic disorders influencing compliance with treatment and outcome. However insight in non-psychotic disorders including affective disorders is variable. In the past, most of the studies on insight primarily focused on schizophrenia and so a substantial number of studies were conducted on it.^[5] But now, insight has become a focus of interest in other major psychiatric disorders, particularly mood disorders.^[6] As in patients with schizophrenia, deficits in insight are common among patients with mood disorders. The high prevalence of the disease and lack of insight into the illness in bipolar disorder and schizophrenia have been reported in several studies.^[4,7-9] Previous studies found that insight in patients with unipolar depression with psychotic symptoms was relatively better than manic

Address for Correspondence:

Dr. Gunjan Solanki

Associate Professor, Department of Psychiatry,
SMS Medical College, Jaipur, India
Email: drgunjanr@gmail.com

patients with psychotic symptoms.^[5,9-11] However, the question of whether patients with unipolar depression differ from those with bipolar depression without psychotic symptoms and with psychotic symptoms i.e., affective spectrum, remained unanswered. The aims of this study were: (1) To evaluate comparative level of insight in patients with unipolar depression, unipolar depression with psychotic symptoms (PS) and bipolar depression with psychotic symptoms (PS). (2) To evaluate the sociodemographic and clinical factors that may be related to possible variations in levels of insight.

Materials and methods

This was a cross-sectional, comparative and observational study performed in Psychiatry O.P.D. of tertiary care hospital. The sample consisted cohort of 20 outpatients with unipolar depression (group 1), 20 with unipolar depression with psychotic symptoms (group 2) and 20 outpatients with bipolar disorder current episode depression with psychotic symptoms (group 3). They were diagnosed by ICD 10 Clinical descriptions and diagnostic guidelines^[12] and assessed independently by two senior psychiatrists not directly involved in the study. The study was approved by the Institutional Ethical Committee. The patients, who gave written informed consent, participated in this study. Identifying information, sociodemographic data, and clinical variables were recorded for each patient. The following scales were applied: Hamilton Depression Scale (HAM-D)^[13] and insight by Item G 12 of the General Psychopathology section of PANSS.^[14]

1. Hamilton Depression Rating Scale (HAM-D)

HAM-D is 17 item questionnaire is a rating scale for depression. It is designed for adults and rates the severity of their depression by probing mood,

feelings of guilt, suicide ideation, insomnia, agitation or retardation, anxiety, weight loss, and somatic symptoms.

The patient is rated by a clinician either on a 3-point (Nine are scored from 0-2) or 5-point (Eight items are scored on a 5-point scale, ranging from 0 = not present to 4 = severe) Likert-type scale. The grading of the scale is as follows: 0-7 = Normal 8-13 = Mild Depression 14-18 = Moderate Depression 19-22 = Severe Depression ≥ 23 = Very Severe Depression

2. Item G12. of the General Psychopathology section of Positive and Negative Syndrome Scale (PANSS) Item G12 (lack of judgment and insight), can be used separately as an insight scale. It is rated on a 7-point scale ranging from "Absent" to "Extreme." "Mild" applies to patients who recognize their illness but clearly underestimates its seriousness and the need for treatment and measures of preventing relapse. "Extreme" applies to patients with emphatic denial of past and present psychiatric illness, delusional interpretation of hospitalization, and lack of cooperation with all aspects of treatment.

Results

Table 1: Distribution of mean Age of the subject

	Group 1	Group 2	Group 3	P Value*
	Mean ± SD (Range)	Mean ± SD (Range)	Mean ± SD (Range)	
Age (in years)	34.1± 7.34 (22-48)	38.45 ± 11.16 (18-61)	36.5±9.51 (21-57)	0.212 NS

*ANOVA

Mean age of group 1, 2, 3 are 34.1± 7.34, 38.45±11.16, 36.5±9.51 years respectively and there is no significant difference in age between all three groups.

Table 2: Sociodemographic profile of subjects

Variable	Group 1	Group 2	Group 3	P Value*
Gender				
male	13 (65)	12(60)	12(60)	0.909 NS
female	7(35)	8(40)	8(40)	
Occupation				
Unemployed	6(30.0)	4(20.0)	4(20.0)	0.926 NS
Semi - skilled Skilled	5(25.0)	5(25.0)	5(25.0)	
Professional	3(15.0)	2(10.0)	2(10.0)	
Student	2(10.0)	1(5.0)	1(5.0)	
House- Wife	3(15.0)	7(35.0)	7(35.0)	
Residence				
Rural	9(45)	11(55)	14(70)	0.231 NS
Urban	11(55)	9(45)	6(30)	

Education				
Nil	1(5.0)	6(30.0)	5(25.0)	0.066 NS
Less than 10th	5 (25.0)	6(30.0)	10(50.0)	
Sec. to Sr. Sec.	8 (40.0)	4(20.0)	3(15.0)	
Graduate & PG	6(30.0)	4(20.0)	2(10.0)	
Religion				
Hindu	15(75)	16(80)	16(80)	0.704 NS.
Muslim	5(25)	4(20)	4(20)	
Marital status single	6(30)	4(20)	6(30)	0.739 NS
married	14(70)	16(80)	14(70)	
Family type				
Nuclear	7(35)	13(65)	7(35)	0.725 NS
Joint)	13(65)	7(35)	13(65)	
Income->20000				
10000-20000	4(20.0)	4(20.0)	7(35.0)	0.166 NS
5000-10000	7(35.0)	5(25.0)	4(20.0)	
3000-5000	8(40.0)	9(45.0)	6(30.0)	
Below 3000	1(5.0)	2(10.0)	3(15.0)	

*chi square test

There is no significant difference between groups in sex, residence, religion, income, occupation, marital status and family type.

Table 3: Insight and demographic factors

Variable	Group1		Group 2		Group3	
Age*	rho =.216	P=.361 NS	rho =.599	P =.005 SIG.	rho =.686	P=.001 SIG.
Sex**	U=40.500	P=.669 NS	U=-47.000	P=.934 NS	U=40.000	P=.502 NS
Education#	H=5.792	P=.122 NS	H=1.553	P=.670NS	H=1.185	P=.757 NS
Occupation#	H=3.085	P=.687 NS	H=3.405	P=.638 NS	H=2.400	P=.663 NS

*Spearman's test ** Mann-Whitney test #Kruskal Wallis test

Statistically significant correlation is present with older age and lack of insight among patients of unipolar depression with PS (rho =.599, P =.005) and bipolar depression with PS (rho =.686, P=.001). No significant difference is seen between sex, education and occupation with insight.

Table 4: Clinical characteristics of subjects

Variable	Group 1	Group 2	Group 3	P Value*
HAMD (Mean ± SD)	19.15± 3.78	21.85± 4.60	20.85±2.36	.075 NS
Insight (Mean ± SD)	2.05±.68	3.35±.87	4.10±1.02	0.00 SIG

*ANOVA

Significant difference in insight is seen in all the groups. The order of lack of insight in the above group is group1< group 2< group3.

Table 5: Correlation of score of HAM-D and lack of insight

	Group 1	Group 2	Group 3
Spearman Correlation (rho)	-.327	.497	.823
Significance	.159 NS	.026 SIG.	.000 SIG.

Group 1 has negative correlation between HAM-D and lack of insight whereas group 3 has stronger significant positive correlation than group 2.

Discussion

In our study, we found a significant difference between age and insight in patients with depression with PS ($P=.005$) and bipolar depression with PS ($P=.001$). This may be due to the long duration of illness in patients with increasing age or multiple episodes but, further evaluation of these factors was not in the scope of this study. This was consistent with previous studies.^[15,16] However, Guclu et al.^[17] and Cassidy^[18] did not find a correlation between insight and age. There was also a strong positive correlation between age and lack of insight in group 2 ($\rho=.599$) and group 3 ($\rho=.686$). But in unipolar depression correlation between age and insight was not significant. This was because in a group of patients with unipolar depression, all patients have relatively good insight i.e. most of them scoring 1 or 2 points on. Our results also showed that poor insight is seen in patients with psychotic symptoms. Similarly, previous studies also found that psychotic depressives had poorer insight than nonpsychotic subjects.^[5,17,19] Presence of psychotic symptoms leads to cognitive deficits in subjects which may reflect poor insight. There was no significant difference in Insight was found in gender, occupation, and education. While Guclu et al.^[17] reported that females have poorer insight during the depressive phase, it was not replicated in our study.

No significant difference ($P=.075$) was seen in the severity of depression among subjects in all the groups. Mean values of lack of insight were significantly greater in bipolar disorder with PS (4.10) than in unipolar depression with PS (3.35), while unipolar depression had the least mean value (2.05) of lack of insight. This shows that bipolar depression with PS had the poorest insight in all groups. Thus we can infer that presence of psychotic symptoms themselves is associated with poor insight. Moreover, the bipolar affective disorder is a psychotic illness in itself which is associated with state and trait-related cognitive decline. A Similar association was also stated by Dell'Osso^[20] and Pini S et al.^[9] that patients with major depression had better insight, followed by the bipolar subtypes that include bipolar depressive symptoms.^[20] In bipolar disorder, levels of insight vary with the severity of mood and appear to affect psychopathology, particularly the presence of suicidal ideations compliance to treatment and quality of life and aggressive behavior, and thus play an important role in the management of these patients. An association between depressed mood and the preservation of insight is observed in several clinical groups,^[4] but the direction of causality is unclear. If an increase in insight leads to recognition of the problem, which causes sadness, then depressed

patients may be more realistic and better able to appraise the consequences of their problems or report more difficulties in function associated with the mood state.^[21] While in a study of insight in unipolar depression patients, a significant number of patients have impaired insight correlating with the severity of depression.^[22] In our study, we found a negative correlation between lack of insight and severity of depression in unipolar depression without psychotic symptoms, whereas there was a positive correlation between lack of insight and severity of depression in unipolar depression with psychotic symptoms and bipolar depression with psychotic symptoms.

Limitations

1. This study was cross-sectional, rather than prospective, limiting our ability to determine whether the group differences in insight in psychotic mood disorders we found are state versus trait related.
2. This study was naturalistic and therefore we did not take into account the potential confounding effect of comorbidity and pharmacotherapy on our results.
3. The insight ratings were not blinded to assessments of psychopathology and diagnosis.
4. Results may be affected by small sample size in each group.

Conclusion

Our study concluded that because insight has important role in management of patient, thus assessment of insight in patient is crucial. Insight is affected by multiple factors; this study shows, bipolarity and presence of psychotic symptoms are associated with poor insight. Management of the patient should incorporate strategies to improve insight for comprehensive care. Age may be factor associated with poor insight in bipolar depression with psychotic symptom patients but needs further enquiry.

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