

# Insight in schizophrenia – a double-edged sword?

Kristyna VRBOVA<sup>1</sup>, Jan PRASKO<sup>1,3</sup>, Marie OCISKOVA<sup>1</sup>, Klara LATALOVA<sup>1</sup>,  
Michaela HOLUBOVA<sup>1,2</sup>, Ales GRAMBAL<sup>1</sup>, Milos SLEPECKY<sup>3</sup>

<sup>1</sup> Department of Psychiatry, Faculty of Medicine and Dentistry, Palacky University in Olomouc, University Hospital Olomouc, the Czech Republic

<sup>2</sup> Department of Psychiatry, Hospital Liberec, Czech Republic

<sup>3</sup> Department of Psychology Sciences, Faculty of Social Science and Health Care, Constantine the Philosopher University in Nitra, the Slovak Republic

Correspondence to: Prof. dr. Jan Prasko, PhD.  
Department of Psychiatry, University Hospital Olomouc  
I.P. Pavlova 6, 775 20 Olomouc, Czech Republic.  
E-MAIL: prasko.jan@seznam.cz

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## Abstract

Lack of insight is defined as a loss of ability to distinguish that one's unusual and unreal experiences should be the symptoms of the psychiatric disorder requiring treatment. Lack of insight may be considered as a core symptom of schizophrenia. The concept of insight has been regarded for a long time as necessary for treatment, which improves adherence and makes a better prognosis. Increased insight in schizophrenia has been associated not only with benefits, but also bring trouble in the form of self-stigma, low self-esteem, reduced patient's hope, diminished quality of life, and increased suicidality. Therefore, insight should be managed with sensitive monitoring of the risk factors, and be gradual, carefully supported by the encouragement of hope and confidence to managing everyday life.

## INTRODUCTION

Insight is defined as a conscious recognition of one's condition. It is a deceptively simple concept that includes beliefs about the nature of the symptoms, their causation, and the most appropriate way of dealing with them. Intellectual insight refers to the contact with the reality of the situation without the ability to successfully use that knowledge to effect adaptive changes in behavior. Emotional insight relates to the deeper level of understanding or awareness, that more likely lead to positive change in personality and behavior. A variety of psychiatric illnesses is associated with impairment of insight and the development of alternative explanations by the patients as the cause of their symptoms. Individuals, who have schizophrenia, also often display a lack of insight regarding their

illness. Lack of insight (i.e. the inability to recognize symptoms, to consider that patient is suffering from a disease, or the acceptance of treatment) is a core feature of the disease for many patients with schizophrenia (David 1990; Kemp & David 1996). It often leads to refusal of potentially helpful treatment or treatment interruptions. Among patients experiencing a first psychotic episode, greater insight is connected with less schizophrenia psychopathology, increased depressive symptoms, suggesting more self-awareness, and self-assessment capabilities (Rathod *et al.* 2005). Therefore, the belief about symptoms and need of treatment are fundamental.

Beyond the simple question of whether the patient shows impairment of insight or not, is quite important to understand, how patients view their symptoms. Because this fact influences their

compliance and future help-seeking behavior. It is important to emphasize that disagreement with the clinician (e.g., with the correct course of action) does not necessarily indicate a lack of insight. A patient might strongly disagree to be admitted to the hospital or to use a particular medication despite having full insight into the nature of his/her symptoms. In these cases, the clinician should make sure that the patient has all the necessary information to make a proper decision before considering the possible need for compulsory treatment.

Moreover, many people experiencing their first episode of schizophrenia, have no personal or family experience of mental disorders, and of course, mostly lack insight about their symptoms of mental illness.

## DEFINITIONS OF INSIGHT AND METHODS OF ASSESSMENT

Insight is usually measured through the patient's understanding of his or her condition and the need for treatment (Turkington *et al.* 2002). There are many aspects of insight, including recognizing the presence or absence of a disorder, the presence or absence of a personal (as opposed to environmental) problem, of a mental or psychological (as opposed to purely physical) problem, regarding the particular type of a psychological problem (e.g., a psychotic patient may argue that he is only stressed up, concerning the need for treatment or the special kind of treatment (e.g., inpatient or outpatient, antipsychotic or antibiotic medication). Assessments of insight should identify what facet of insight is being compromised. A possible clinical rating of insight is rated on a 6-point scale from one to six.

1. Complete denial of the disorder.
2. Small awareness of being sick and needing help, but denying it at the same time.
3. Awareness of being disordered, but it is ascribed to external or physical factors.
4. Awareness of being sick, due to something unknown in self.
5. Intellectual insight: Awareness of being ill and that the symptoms/failures in social adjustment are in line for to own particular irrational feelings/thoughts; yet does not apply this knowledge to the current/future experiences.
6. True emotional insight: It is different from intellectual insight in that the awareness leads to significant basic changes in the future behavior and personality.

Perhaps the fundamental problem should be the setting of empirical studies on insight, which is an absence of a reliable characterization of insight, its measurements, and evaluation. This creates it problematic to draw usable assumptions and significant links between the studies. In general, approaches in this area can be divided into those involving (1) categorical and (2) continuous approaches.

### (1) Categorical approaches to studying insight

Eskey (1958) defined insight as "verbalized awareness on the part of the patient that impairment of intellectual functioning existed," and then branded patients into those with insight, those with partial insight, and those with no insight. In a study by Lin *et al.* (1979), insight was defined as "a recognition of the existence of problems and the need for medical intervention." Insight was considered to be an all-or-none conception, being either present or absent. Thus, although this method of assessment may be controlled and reliable, its validity is problematic.

A similar model of insight as an all or no occurrence was used by Heinrichs *et al.* (1985), who defined insight as "a patient's ability, during the early phase of a decompensation, to recognize that he or she is beginning to suffer a relapse of his or her psychotic illness." Bartko *et al.* (1988) on the other hand, defined lack of insight as for when "the patient fails to acknowledge his/her emotional state and behavior assessed as pathological by the physician, and does not perceive the necessity of treatment." This combined definition incorporates components from earlier definitions including a recognition and needs for treatment and further comparative decision.

Studies comprising categorical approaches to insight valuation tend to use structured schedules such as item 104 in the Present State Examination (PSE) (Takai *et al.* 1992) or a similar item from Manual for the Assessment and Documentation of Psychopathology (AMDP). For example, Cuesta & Peralta (1994) count on a mixture of three AMDP items, explicitly (1) lack of feeling ill, (2) lack of insight, and (3) un-cooperativeness, as a global index of insight, but they do not, in fact, postulate what they mean by insight itself. Obviously, there are more levels of insight, but some of studies classified patients into those with illness consciousness and those without illness – consciousness, with the following consequences. Also, again the defining criteria for this splitting up were not definite.

### (2) Continuous methods for studying insight

Trying to go beyond the all-or-none attitude, efforts have also been made to evaluate insight in a graded way with structured schedules founded on either a unitary concept 1 or multidimensional models (Davis 1990; Amador *et al.* 1993). Again, investigators using this approach have used various definitions and methods of evaluation. McEvoy *et al.* (1989a), who was perhaps the first to develop a standardized questionnaire to evaluate insight as a continuous process, defined it regarding a correlation between the conclusions made by patients and by clinicians. They state that "patients with insight judge some of their perceptual experiences, cognitive processes, emotions, or behaviors to be pathological in a way that is congruent with the judgments of elaborate mental health professionals, and that these patients accept as true that they need psychiatric treatment, at

times containing hospitalization and pharmacotherapy” (McEvoy *et al.* 1989a). Their Insight and Treatment Attitude Questionnaire (ITAQ), validated against recorded extensive interviews, was based on questions linking to patients’ approaches toward hospitalization, medication, and the need for follow-up evaluation.

In a dissimilar manner, Greenfeld *et al.* (1989) completed an empirical study of patients’ outlooks about their experiences, and on the basis of patients’ explanations proposed a model whose dimensions related to (1) views about symptoms, (2) views about existence of an disease, (3) assumptions about etiology, (4) views about vulnerability to relapse, and (5) views about the importance of treatment.

With the intention of operationalizing and standardizing the assessment of insight in psychotic patients, both David (1990) and Amador *et al.* (1991; 1993) had also suggested multidimensional prototypes for the insight. David (1990) stated that insight is composed of three separate, corresponding dimensions: (1) recognition that one has a psychiatric disorder, (2) agreement with treatment, and (3) ability to relabeled psychotic experiences (delusions and hallucinations) as a pathological. Thus, the configuration of insight is seen as comprising of interrelating components, but it would have been interesting to discuss the theoretic origin of these proportions. Proportions 1 and 3 seems to be similar to the secondary elements of both Jaspers’ (1959) and Lewis’ (1934) definitions of insight, explicit attribution of the pathological process to a psychiatric disorder. In David’s description, this pathological process is divided up into (1) the process as a whole (involving all symptoms) and (2) particular symptoms (delusions and hallucinations) only. This subdivision is important in that it suggests the possibility of the variance of insight about different symptoms, and it would have been useful to explore this further and to discuss the choice of the particular symptoms (delusions and hallucinations). The element relating to treatment compliance seems to be derived from evidence based on previous empirical studies indicating that (psychotic) patients with insight are more likely to accept treatment than those without insight (Bartko *et al.* 1988; Cuffel *et al.* 1996).

Amador *et al.* (1991) also suggest a dimensional approach to insight, with their dimensions, was grounded on observations of the multiplicity of ways in which insight and associated expressions are used within the psychiatric writings. However, the fact that Amador *et al.* present somewhat different multidimensional models about their theoretical and empirical studies could lead to confusions. It seems that in the principal (Amador & Strauss 1993), insight is described as a multidimensional construct consisting of (1) awareness of the signs, symptoms, and consequences of illness, (2) general attribution about disease and specific attribution about symptoms and their consequences, (3) self-concept formation, and (4)

psychological defensiveness. However, in their review, Amador & Strauss (1993) distinguished only two primary factor dimensions of insight, namely “awareness of illness and attribution regarding the disease.” Their scale to measure insight (The Scale to Assess Unawareness of Mental Disorder [SUMD]) (Amador *et al.* 1993) on the other hand, seems to be grounded on yet diverse dimensions, i.e., awareness of disorder (general and specific symptoms), attribution regarding disorder and symptoms, achieved effects of drugs, and outreach of social consequences of having a psychiatric disorder. Both current and retrospective views are assessed in association to these dimensions. In their inspiring study scrutinizing insight in 412 patients (mainly schizophrenic and schizoaffective), Amador *et al.* (1994) use an shortened version of their scale that appears to be based on yet different dimensions, having specifically removed dimensions related to retrospective awareness and attribution regarding disorder/symptoms, as well as those linking to some discrete symptom items.

Using multidimensional models of insight can lead to surprising and unpredictable results. For instance, poor insight has been associated with lesser treatment adherence (Bartko *et al.* 1988; Cuffel *et al.* 1996), poorer clinical outcome (Schwartz 1998), poorer social function (Lysaker *et al.* 1998; Francis & Penn 2001; Olfson *et al.* 2006), vocational dysfunction (Lysaker *et al.* 2002), and difficulties developing therapeutic relationships with mental health professionals (Frank & Gundersen 1990). On the other hand, better insight has been associated with greater levels of dysphoria (Thompson 1988; Amador *et al.* 1994; Dixon *et al.* 1998; Mintz *et al.* 2003), lowered self-esteem (Warner *et al.* 1989), and decreased well-being and quality of life (Hasson-Ohayon *et al.* 2006). The phenomenon of insight often referred to as “poor insight,” or “lack of awareness”, has shown a pattern of apparently contrary links with the outcome.

## INSIGHT AS A POSITIVE FACTOR INCREASING ADHERENCE

Poor insight also often interferes, leading to poor adherence. Patient’s attitudes toward antipsychotic medications highly correlated both with insight and positive relationships with staff (Day *et al.* 2005; Ramdour *et al.* 2015). Similarly, a weak therapeutic alliance and low insight were associated with poor adherence in patients with schizophrenia or schizoaffective disorder, who were hospitalized (Misdrahi *et al.* 2012). Also, one of the factors associated with better outcome in CBT of psychosis is better clinical and cognitive insight (Emmerson *et al.* 2009; Perivoliotis *et al.* 2010). Also, cognitive impairment is associated with reduced insight and also reduced the benefit from psychiatric rehabilitation approaches (Smith *et al.* 1999).

Furthermore, Novick *et al.* (2015) explored the relationship between insight and medication adherence

in 903 patients with bipolar disorder or schizophrenia who participated in an observational study conducted in Europe on the results of patients treated over a 1-year period with two oral formulations of olanzapine. Patients with schizophrenia had lower insight versus bipolar ones. Better insight was associated with higher adherence and to a stronger therapeutic alliance. A path analysis revealed a favorable effect of insight on alliance and adherence and that lower clinical severity (lower CGI score) was related to the stronger alliance.

If nonadherence is a significant problem, a thorough assessment should include evaluation of barriers to adherence, including poor insight or awareness of illness and the need for treatment (Velligan *et al.* 2007).

Poor judgment, which is also characteristic and may be related to lack of insight, may lead to dangerous behavior. For example, a patient walking barefoot in the snow because of the feeling that surveillance cameras could trace her or his shoes would be displaying both poor judgment and poor insight. Insight can be ascertained by asking patients about their understanding of why they are being evaluated by a psychiatrist or why they are receiving a certain medication.

Finally, poor insight may lead to dangerous behavior, negatively impacts the ability to identify physical health problems, delay help seeking to result in premature physical deterioration and mortality.

## **INSIGHT AS A FACTOR INCREASING DEPRESSION AND SUICIDALITY AND DECREASING SELF-ESTEEM AND QUALITY OF LIFE**

### *Depression, self-esteem, and self-stigma*

Clinical insight in schizophrenic patients has been associated with low mood. Cognitive insight is a newly defined concept, relating to the capability to self-reflect to the degree to which patients are over-confident about their interpretations of illness-related experiences and is related to clinical insight. The idea of cognitive insight was presented in 2004 to define the capacity of patients with schizophrenia to distance themselves from their psychotic experiences, reflect on them, and respond to corrective feedback. The Beck Cognitive Insight Scale (BCIS) was established to assess these characteristics of cognitive flexibility and to complement scales that describe the lack of awareness of the psychiatric disorder and its features (Riggs *et al.* 2012). Palmer *et al.* (2015) investigated whether there is a positive relationship between cognitive insight and mood. Their literature review indicated that there was a significant positive correlation between insight and depression scores, where the low mood was related to higher insight scores.

These findings, which are consistent with others (Moore *et al.* 1999; Kravetz *et al.* 2000; Hasson-Ohaion *et al.* 2006), also hypothetically raise a test to the vision that insight, as traditionally defined, is always

desirable for people with schizophrenia. In fact, some of stigmatizing views about psychiatric disorders may find accepting their disorder burdensome in some ways. This is in agreement with the findings suggesting that benefit from psychiatric treatment is related to the meanings persons assign to both their disease and the treatment itself (Lacro *et al.* 2002; Tait *et al.* 2003; Deegan 2005).

Also in cognitive therapy, increased insight at the beginning led paradoxically to increased dropout rates, and when such participants remained in the study, they were less likely to improve regarding their symptoms and insight (Turkington *et al.* 2002). The growth of the acceptance of the illness has also been associated not with improved overall symptom outcomes, as is insight generally, but with increased depression (Rathod *et al.* 2005). It is, for this reason, that a psychoeducation needs to be embedded in a cognitive-behavioral framework and that careful consideration needs to be given to its use, in particular with the emphasis on the utilization of the diagnostic term "schizophrenia."

Valiente *et al.* (2015) examined the patterns of the link between insight and psychotic psychopathology, satisfaction with life, depression, anxiety, and self-esteem, as moderated by self-stigma and experiential avoidance, in a sample of 47 patients with persecutory beliefs and diagnosed with schizophrenia or other psychotic disorder. Moderation analyses confirmed the significant influence of internalized stigma and experiential avoidance. The existence of insight was connected with depression in patients with high levels of self-stigma. Whereas, the absence of insight was associated with a greater life satisfaction when there were high levels of experiential avoidance.

### *Quality of life*

Several studies have examined the relationship between insight and the quality of life.

The aim of Karow *et al.* (2008) study was to explore the relationship of self-rated and expert-rated insight into disorder with subjective quality of life. Patients with real insight into illness reported significantly lower physical health, vitality, psychosocial, affective and general quality of life compared to patients with poor insight. Good insight was significantly associated with other parameters of clinical and social functioning and depressive symptoms. Patients with acute schizophrenia and greater insight realize their restrictions more clearly, which contribute to poor quality of life but were stronger integrated into social networks.

Staring *et al.* (2009) examined whether perceived stigma moderates the adverse associations of real insight. Participants were 114 patients with schizophrenia spectrum disorders. Good insight was connected with high service engagement and high compliance, on the other side real insight was also linked with depressed mood, low quality of life, and negative self-esteem. This association was strong when stigma was high and

weak when stigma was low. These results advocate that stigma moderate the associations of insight with depression, low quality of life, and negative self-esteem. Patients with real insight, who do not recognize much stigmatization, appear to be the best across some result factors. Those with poor insight have problems with facility engagement and drug adherence. Patients with good insight accompanied by self-stigma have the highest risk of experiencing a low quality of life, bad self-esteem, and depressed mood. A clinical consequence is that when it is attempted to increase insight, perceived stigma should also be addressed.

Aghababian *et al.* (2011) enrolled 153 schizophrenic patients to the study impact of insight on the self-reported quality of life. Patients with good insight commonly described a lower global quality of life score, whatever the insight domains. The insight of mental disorder is the most relevant domain affecting the quality of life levels. Psychological comfort, self-esteem, physical well-being, and independence rates were significantly lower for patients with real insight. Multivariate analysis exhibited that insight of mental disorder is the only parameter linked to the subjective quality of life index. No links were recognized between other insight domains and subjective quality of life index. Patients with good insight might realize consequences of their mental illness with restrictions on daily living and alteration of their quality of life, while patients with poor insight might partially overrate their quality of life and present themselves as more competent.

In summary, studies of the association between insight and quality of life have produced inconsistent results.

### Suicidal behavior

The risk of suicide in patients with schizophrenia is significant. Many clinicians hypothesize that psychotic symptoms have a protective feature in masking the harsh realities of the burden of the severe psychiatric disorder. Insight into schizophrenia has been linked to suicidality, although inconsistently (López-Moríñigo *et al.* 2014; Barrett *et al.* 2015; Villa *et al.* 2017; Masson *et al.* 2017). The co-variation between insight and suicidality over time is under-investigated. Improvement in insight and symptomatology can bring with it an increased exposure to this burden, thus aggregate the probability of possible escape through suicide. López-Moríñigo *et al.* (2014) tested the relationship between suicidal behavior preceding first-episode psychosis (FEP) and insight dimensions at treatment onset in 112 schizophrenic patients. There was the direct link between previous suicidality and all insight areas. However, these relations did not survive multivariable regression models, which showed gender (female), shorter duration of untreated psychosis, and symptoms of depression and disorganization – to intermediate the impact of suicidal history on insight, and, thus, to underlie the latter. Insight dimensions in FEP patients

were influenced by having suicidal antecedents through some mediating variables such as gender, shorter duration of untreated psychosis, and depression. As the suicidal history is linked with higher intensities of both depression and insight at first presentation, these three variables might be valuable in predicting more suicidal events.

Barrett *et al.* (2015) studied 146 patients with the first episode of psychosis over one year, concentrating on the relationship between insight and suicidality. At the starting point, 37% of patients were suicidal, significantly decreased to 20% at follow-up. The influence of insight on suicidality was different in a variety of ways at various time-points, with baseline insight increasing and insight at follow-up reducing the risk of suicidality at follow-up. Patients with constant degrees of insight across baseline and follow-up did not vary in danger for suicidality at follow-up. Nevertheless, patients, who lost insight from baseline to follow-up, were more often suicidal at follow-up, while patients with increased insight were more seldom suicidal at follow-up. Other predictors of suicidality at follow-up were a longer duration of untreated psychosis, a higher number of depressive episodes before study entry, more suicide attempts six months before follow-up, and depression at follow-up.

In summary, the results indicate that the effect of insight on suicidality in FEP-patients depends on the time of assessment and of changes in insight. Acquisition of insight during treatment was related to reducing the risk of suicidality, while losing insight had the contrary effect, underlining the need to monitor insight over time and tailor interventions according to illness phase.

## CLINICAL IMPLEMENTATIONS AND BRIEF RECOMMENDATIONS

The absence of awareness of the fact that some beliefs are part of the disease is common in patients with schizophrenia. A psychotherapist helps a patient to check whether his or her reality coincides with that of the therapist. The therapeutic intervention then becomes a frank discussion of what schizophrenia is and how the patients feel about themselves. This objectifying of psychotic or negative symptoms can prove of enormous value in allowing the patient to feel more in control of the disorder.

In cases when the patients are very deluded or have a lack of insight into the symptoms, trying to persuade them that eliminating their symptoms, the experiences that they believe to be real, can be counter-productive and jeopardize the therapeutic relationship. However, attempting to reduce distress is a more viable alternative for a collaborative goal.

Individualizing psychoeducation helps people feel listened to and understood, and this approach adds to its effectiveness. Early on during the assessment process, such questions as these should be asked:

- What would you like to know what has happened to you?
- How has it been described to you previously?
- How did you feel about that?
- What did it mean to you?
- If the person is not aware of his/her diagnosis, feels uneasy, or rejects it, we do not continue to emphasize it. Three components of insight have been outlined (David 1990). The client may:
  - Accept the need for treatment.
  - Accept that he or she has an illness.
  - Accept that voices or delusions are originating from within him- or herself.

There is evidence that increased acceptance of the need for treatment and recognition that the voices or delusions are originating from within oneself both correlate positively with improved outcomes. It seems reasonable, therefore, to focus on these matters.

Whenever descriptive terms are needed, the names of the four subgroups identified earlier are used. Conditions related to stress sensitivity, drugs, past trauma, and anxiety, seem relatively easy for people to accept. Discussions about whether they have “schizophrenia” are potentially damaging to engagement and therapy. The most important consideration is that they have problems that may benefit from collaboration with mental health services and the treatment options available.

Education that normalizes appropriately can be highly valued. Professional terms should not be used if they are not explained fully. However, there is a place for developing their use by clients to understand better their experiences, give them a name, and in the process be able to distance themselves from them. It can allow them to analyze the experiences more objectively.

Discussion of medication and other treatment interventions is also frequently necessary (e.g., orienting the client to cognitive therapy, as discussed previously).

It seems that cognitive therapy is better than supportive counseling or treatment as usual for florid hallucinatory states. For the acutely psychotic person, who is often completely lacking insight and psychological treatment, would appear to be crucial. The key issues are to provide brief (10- to 15-minute) regular sessions two to three times per week and to initially focus simply on developing a rapport and a trusting relationship, often aided by at a pace dictated by the person. A series of small clear steps are taken to the perceived areas of distress with the focus on clarifying concerns. Repetition is often necessary. Key issues for the case formulation will often be disclosed during these sessions that should be carefully noted for future reference. Information is delivered only about such matters as the ward routine, medication side effects, relaxation training, and how to elicit support if needed. These sessions will often seem to be initially completely dominated by the client if he or she is actively expressing psychotic symptoms. When the customer's behavior is particu-

larly thought-disordered, communication can become very difficult. The therapist should gently structure sessions without attempting to do too much therapy work until the person feels insufficient control and able to trust enough to begin working in areas of distress. A fundamental therapist error in such situations is to try to move on to symptom management before the person is ready. The key advice in such cases is to go slowly, be open and empathic, and let the person lead until trust begins to develop before moving on to reasoning with him or her and developing alternative explanations.

It is of particular importance when insight increases due to alternative explanations of their delusions being accepted to assess suicidality. The person who comes to a realization – especially abruptly – that he has had a “nervous breakdown” described as “schizophrenic” may have an increase in depression with some increase in suicidal ideation due to the very negative associations that surround the label of schizophrenia. People with schizophrenia often have a poor quality of life and have experienced many losses. Working with the pros and cons of continuing, what has been a distressing life (from the viewpoint of the actively suicidal person) obviously requires careful handling.

## CONCLUSION

Achieving the insight is an important target for the clinical management and treatment of the patients with schizophrenia. However, the insight can also lead to psycho traumatization and self-stigma with lowered self-esteem, which reduces the patient's hope for a good future and follow to resignation, substance abuse, and increased suicidality. Therefore, insight should be managed with sensitive monitoring of the risk factors and take place gradually, carefully and in conjunction with the encouragement of hope and support the confidence in life coping.

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