The Paradox of Insight

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Abstract

Previous research has linked higher levels of insight and awareness to better treatment outcomes. However, higher levels of insight have also been associated with higher levels of depressive symptoms, and hopelessness, and lower levels of self-esteem, quality of life, and psychosocial functioning. Inconsistent research exists in understanding the effects of insight, as well as understanding the various variables that influence the effect, such as neurocognitive functioning. Investigation into the complexities in defining and measuring insight and treatment outcomes are reviewed. Due to the increase in depressive symptoms and hopelessness, the increased risk of suicidality is also highlighted. The limitations of current therapeutic approaches are reviewed, advocating for the implementation of facilitating a purposeful and useful insight from a recovery-oriented therapy perspective. Narrative therapy, metacognition, self-complexity theory, and Adlerian theory are highlighted as therapeutic solutions for this insight paradox.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Defining and Assessing Insight</td>
<td>8</td>
</tr>
<tr>
<td>Assessment Methodologies</td>
<td>9</td>
</tr>
<tr>
<td>Individual Assessments</td>
<td>10</td>
</tr>
<tr>
<td>Defining and Assessing Treatment Outcome Variables</td>
<td>12</td>
</tr>
<tr>
<td>Assessing the Process of Change</td>
<td>12</td>
</tr>
<tr>
<td>Clinical Implications</td>
<td>13</td>
</tr>
<tr>
<td>Impaired Insight among Physical Conditions</td>
<td>13</td>
</tr>
<tr>
<td>Dementia</td>
<td>14</td>
</tr>
<tr>
<td>Strokes and Traumatic Brain Injuries (TBI)</td>
<td>15</td>
</tr>
<tr>
<td>Impaired Insight among Mental Disorders</td>
<td>16</td>
</tr>
<tr>
<td>Bi-polar Disorder</td>
<td>16</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>17</td>
</tr>
<tr>
<td>Individual research studies</td>
<td>18</td>
</tr>
<tr>
<td>Meta-analysis</td>
<td>22</td>
</tr>
<tr>
<td>Postpsychotic depression (PPD)</td>
<td>23</td>
</tr>
<tr>
<td>Suicidality</td>
<td>24</td>
</tr>
<tr>
<td>Insight and Cognitive Functioning In Mental Disorders</td>
<td>24</td>
</tr>
<tr>
<td>Inconsistent Individual Research Studies</td>
<td>26</td>
</tr>
<tr>
<td>Executive Function</td>
<td>26</td>
</tr>
<tr>
<td>Attention and mental control, executive function, fluency, andlogical memory</td>
<td>29</td>
</tr>
</tbody>
</table>
PARADOX OF INSIGHT

Symptom misattribution and executive function 30

Meta-analysis 31

Factors that Influence Insight and Treatment Outcome 33

Coping Styles in Patients with TBI 34

Coping Styles, Hope, and Stigma 34

Stigma, Hope, Self-Esteem, and Insight 38

Combinations of Insight and Stigma 39

Suicidality 41

Executive Function 42

Insight and Depression 44

Social Rank 45

Therapeutic Solutions for this Paradox of Insight 47

Changing Paradigms: Recovery-Oriented Approach 47

Narrative and Metacognition 49

Essential narrative elements 52

Self-Complexity 54

Application of Recovery-Oriented Approach 56

Adlerian Theory 57

Conclusion 62

References 63
The Paradox of Insight

From a therapeutic perspective, insight and awareness of one’s diagnosed condition is a precursor for therapeutic change and growth. Numerous studies have illustrated a lack of insight and awareness results in poorer treatment adherence, poorer clinical outcome, poorer social function, vocational dysfunction, and difficulties working with mental health professionals (Lewis, 2004; Lysaker, Roe, Yanos, 2007; Martens, 2009). In addition to those factors, patients with impaired insight diagnosed with schizophrenia are more likely to be assaultive, noncompliant with treatment, have longer and more frequent hospital stays, and require more seclusion and restraint (Lewis). Due to the lack of awareness of realizing one has a disorder or condition, the refusal or poor adherence to prescription medication increases, hindering the recovery process (Lysaker, France, Hunter, & Davis, 2005). Insight, operationally defined by Minez et al. (as cited in McLeod, Coertze, & Moore, 2009) as (1) awareness that one has a mental disorder; (2) the attribution of the symptoms to the disorder; (3) acknowledgement of the need for treatment; (4) awareness of the specific signs and symptoms of the disorder; and (5) understanding the social consequences of the disorder, is a widely shared therapeutic goal within the mental health field that spans across all diagnoses within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-TR, American Psychiatric Association, 2000).

However, numerous studies also linked greater insight to higher levels of dysphoria, hopelessness, and depression, as well as lowered self-esteem, and decreased well-being and quality of life (Lysaker, Roe, et al., 2007). In addition, the risk of the development of anxiety, poor psychosocial adjustment, and social dysfunction are also increased among patients who have higher levels of awareness and insight into their condition and consequences of their
condition (Martens, 2009). Given the previous research on suicide risk factors, patients who experience hopelessness and/or depression are at an increased risk of suicide (Lewis, 2004). Thus a paradoxical relationship of insight exists; the therapeutic relevance of increasing insight is well supported, as well as the increased risk of doing so.

Understanding how and why insight impairment occurs is critical for implementing interventions and treatment approaches to increase insight. Various hypotheses exist regarding the etiology of insight impairment. A plethora of mental and physical conditions, in which impaired insight is observed, are also associated with impaired neurocognitive abilities. These neurocognitive deficits have been hypothesized to limit the ability of an individual’s frontal lobe executive function, a mechanism responsible for creating this insight and awareness of self (Lewis, 2004; Lysaker, France, et al., 2005). On the other hand, this observed lack of awareness can also serve an adaptive and protective purpose, safeguarding an individual’s self esteem against negative appraisals due to the consequences of accepting his or her disorder. Additional factors influence the social consequences, such as the extent of internalized highly stigmatized and stereotypic beliefs about mental disorders (Lysaker, France, et al).

Once an individual accepts his or her diagnosis, learns more about the disorder, accurately attributes symptoms to the disorder, realizes the need for treatment, and understands the social consequences of the disorder, he or she must also cope with the information gained through this insight. If a person is not prepared to psychologically, emotionally, and cognitively cope and adjust to this information, maintaining these insight impairments, and thus remaining unaware or in denial, can be seen as beneficial (Lewis, 2004; Lysaker, France, et al, 2005).

However, remaining unaware of one’s diagnosis, by adhering to these inaccurate and unrealistic views, beliefs and expectations, results in maladjustment and poor outcome. Thus
the relationship between impaired insight to poorer treatment adherence, poorer clinical outcome, poorer social function, vocational dysfunction, and difficulties working with mental health professionals can be clearly understood (Lysaker, Roe, et al., 2007; Martens, 2009).

Attention and further study of the consequences of insight impairment are warranted due to the wide array of physical and psychological conditions and disorders that limit or impair insight. These impairments may be temporary or permanent. As insight is increased, psychosocial factors such as social stigmatization, attitudes and beliefs about one’s identity and meaning, self-complexity, self-efficacy, and personal narratives have been demonstrated to influence how this insight is perceived and integrated, maximizing or minimizing the potential detrimental effects of the information (Lewis, 2004; McLeod, et al., 2009). The rejection of stigmatizing beliefs about mental illness has been illustrated to buffer against feelings of hopelessness and low self-esteem (Lysaker, Roe, et al., 2007).

Thus, therapeutic attention and treatment should not be solely focused on increasing insight, but providing patients with appropriate coping skills and cognitive frameworks to interpret and integrate it. By this process, a usable insight that preserves hope can be accomplished, thereby creating conditions in which individuals can adjust to these realized impairments, and successfully and meaningful reintegrate into life. Acceptance of one’s limitations and new realities also involves a process of mourning the expectations and goals in the present and future that are no longer realistic (Lewis, 2004).

The aim of this paper includes a literature review exploring the inconsistencies studying the construct and assessment of insight, as well as an overview of research of physical and mental conditions with impaired insight. The detrimental effects of increasing insight will be explored, in addition to identifying related factors that influence the perception of an individual’s
insight, thus impacting treatment outcomes. Finally, this paper will highlight the limitations of current interventions and treatment approaches which fail to adequately address the detrimental effects of increasing insight. The philosophy of Adlerian theory will be integrated with current research to offer more effective treatment approaches and interventions. These interventions and treatments aim to: increase purposeful and usable insight while maintaining hope; help individuals foster worth, meaning, and significance outside their diagnosis label; deepen and richen their personal narratives; and highlight their strengths, capabilities, and competencies. As a result of this purposeful and recovery oriented insight approach, individuals’ hope in themselves and future will be sustained, and will encourage them to engage in their daily lives meaningfully, despite the limitations of their disorder.

**Defining and Assessing Insight**

Among theorists, researchers, and clinicians, inconsistent conceptualizations and definitions of insight exist. Variations and discrepancies include defining insight as a single item construct, or as a complex multidimensional categorical construct. Schwartz (1998) noted that because of these inconsistencies, different methods of assessing the level of insight impairment in research studies are used, producing varying, and sometimes contradictory, correlations and relationships to other variables (e.g., depressive symptoms, clinical symptoms, psychosocial adjustment, self-esteem, hopefulness, and quality of life). Because of the discrepancies in defining, and measuring insight, the results of these studies limit generalizability and applicability to therapeutic practice. Throughout this paper, attention will be focused on identifying the research methodologies in assessing insight, thereby exploring the strengths and limitations of each method used.
Because of the difficulties associated with assessing a highly subjectively experienced phenomenon such as insight and awareness, a variety of assessments have been used. In an attempt to increase reliability and validity, a shift from less subjectivity to greater objectivity in standardized assessments has occurred in research on this topic. However, in an effort to increase standardization, the breadth and depth of understanding insight is also restricted, such as assessments using a limited number of responses or decreased attention to individual answers that do not fit adequately in the predetermined categories (Schwartz, 1998).

**Assessment Methodologies**

Amador (as cited in Schwartz, 1998) offers four types of assessment tools that have been used to measure insight impairment: (1) qualitative descriptions of free responses to open questions, (2) clinical descriptions of free responses to controlled stimuli, (3) systemized scoring of clinical responses to open questions and (4) systemized scoring of responses to controlled stimuli. Qualitative descriptions of free responses to open questions, used in the early to mid twentieth century, provided a large range of answer variability, thus limiting reliability and validity. Because of the open-ended questions, the researcher’s biased views and interpretations were not controlled. As research transitioned into clinical descriptions of free responses to controlled stimuli, the range of answer variability was decreased through the use of structured questions. However, the interpretation and categorization of these free responses were not standardized, allowing for biases, such as a confirmatory bias, when researchers interpret the answers and data to fit the proposed theories and models (Schwartz, 1998).

The third type of assessment, systemized scoring of clinical responses to open questions provided a standardized scoring system to categorize answers. This methodology allows for a greater range of answers, because it does not limit the respondent’s answer to a set of
predetermined answers, but allows freedom to answer. However, due to this range of responses, the ability to validly and reliably fit responses into the predetermined categories is limited. Finally, the fourth type of assessment provides the most accurate and reliable method for measuring insight. Using systemized scoring of responses to controlled stimuli, such as a semi-structured interview, participants are able to respond to questions within a limited number of categories. Due to the smaller variability of answers, greater reliability and validity is attained, when categorizing these answers by the systemized rating. Examples of this type of methodology include Likert scale ratings of various categories of insight, and multiple choice statements, which participants select to best answer the question. However, in these types of assessments, ceiling and floor effects (e.g., the highest and lowest rating may not adequately assess the individual’s impairment because the phenomenon level is above and below the possible score, respectively) and individual response differences (e.g., over or under exaggeration of impairment) are not accounted for, and may confound the results of these assessments (Schwartz, 1998).

*Individual Assessments*

The Positive and Negative Syndrome Scale (PANSS) includes a single item, G12, to assess the participant’s insight and judgment, as rated by a clinician on a seven point scale. The participant’s insight and judgment score is based on the participant’s perceptions of past or present illness and symptoms, the need for treatment, decisions in the past and present, understanding of the consequences of those decisions, and short-term and long-term future planning (Schwartz, 1998). In addition to measuring positive, negative, and general symptoms, this insight score is commonly used in research analysis. However, because of the methodology, insight is measured as a single score, thereby limiting the depth of the understanding of the
complexities of the construct, such as relationships between a subscale of insight and treatment outcomes.

The Insight and Treatment Attitude Questionnaire (ITAQ) consists of eleven items assessing the participant’s insight into mental illness, need for treatment, and need for medications by clinician’s rating on a three point scale (i.e., no insight, some insight, good insight). Although this assessment includes three aspects of insight, critiques of this assessment include a lack of understanding scoring (e.g., How is a score of 2 decided upon? What characteristics and answers qualify this score?). Additionally, the three aspects assessed do not create an understanding of a multidimensional view of insight, but rather support the view of insight being a single and simple concept, thereby limiting further understanding of subcomponents (Schwartz, 1998).

The Scale to Assess Unawareness of Mental Disorder (SUMD) is another standardized assessment with systemized scoring, accomplished by a semi-structured interview consisting of clinician’s rating on a five point scale. Schwartz (1998) advocates the use of this assessment as it provides, in his opinion, the most comprehensive understanding of insight. The SUMD is based on a conceptualization of insight as a complex, multidimensional phenomenon with many independent but interrelated components. The SUMD measures not only the patient’s unawareness of the disorder (i.e., lack of acknowledgement of the occurrence of symptoms of the disorder), but also measures incorrect attributions of the disorder’s symptoms (i.e., beliefs that experienced symptoms of the disorder are unrelated to the disorder). Thus the client’s general awareness and symptom awareness in the past and present are measured in this method, thereby allowing for correlations between specific subcomponents of insight and treatment outcomes (Schwartz, 1998).
In addition to clinician ratings, insight can be measured through self-reports. The Insight Scale (Birchwood, et al., as cited in Cooke, et al., 2007) measures by a self-report three dimensions of insight: awareness of illness, awareness of symptoms, and awareness of the need for treatment. However, because of the increased subjectivity involved in self-reports, as well as the desire to answer in socially acceptable ways, self-reports have limited validity and therefore may not accurately assess insight impairment.

**Defining and Assessing Treatment Outcome Variables**

In addition to the discrepancies involved in defining and assessing insight, discrepancies exist regarding variables and outcomes related to treatment and recovery. By measuring the impact of one’s insight impairment on treatment outcomes (e.g., clinical symptoms), researchers and clinicians can further understand variables that influence the therapeutic process, thereby implementing more effective interventions and processes. However, discrepancies exist in determining which treatment outcomes, and variables should be highlighted, investigated, and measured (Schwartz, 1998).

**Assessing the Process of Change**

The therapeutic growth of clients in the treatment and recovery process can be measured by a variety of external and internal changes or domains that demonstrate the influence of insight impairment. Externally manifested changes (e.g., clinical symptoms, frequency of socialization, and employment) have been objectively measured by the ratings and observations of clinicians. Internally experienced changes (e.g., quality of life (QOL), sense of purpose in life, self-esteem, and hopefulness) have been assessed; however involve a greater extent of subjectivity than externally manifested symptoms (Schwartz, 1998). Additional measures of self-esteem, QOL, psychosocial adjustment and hopefulness have also been investigated and demonstrated to have
varying correlations to insight impairment. Different theoretical approaches may place varying emphasis on specific treatment goals (Lysaker & Lysaker, 2010). These overarching goals of therapy influence the variables chosen to investigate in research methodology. If one of the main goals or outcomes of therapy is symptom management, the frequency and severity of clinical symptoms, depression, and anxiety experienced can be used to assess this.

**Clinical Implications**

From these studies exploring insight impairment and treatment variables, further implications exist when combined with previous research on treatment variables and risk factors. For example, previous research has identified hopelessness and depression as risk factors for suicide. The results of the research illustrating a correlation between increased insight and hopelessness and depression can therefore be applied to the suicide risk factor research, therefore resulting in more accurate and effective diagnosis and treatment (Lewis, 2004; Martens, 2009).

Without adequate understanding of the risks associated with increasing insight in therapy, detrimental effects, such depression or suicide can occur. It is the ethical responsibility of all clinicians to understand the factors and risks associated with increasing impairment to provide adequate treatment in an attempt to minimize these risks. Thus further research and understanding into how insight influences treatment variables is extremely pertinent in developing and implementing effective interventions and treatments (Lewis, 2004; Martens, 2009).

**Impaired Insight among Physical Conditions**

A variety of conditions, physical and mental, can temporarily or permanently impair an individual’s insight. Based on the type of condition surrounding this impairment, producing a pre-morbid level of insight may or may not be possible.
Dementia

Dementia is a condition characterized by the impairment of insight. Due to the permanent cognitive deficits responsible for this insight impairment, it is not possible for clients diagnosed with dementia to regain insight back to their pre-morbid functioning. Ott and Fogel (1992) investigated the risk level of depression in individuals with dementia. The results indicated that individuals with mild or early Alzheimer’s dementia are at risk for depression due to their relatively high level of intact insight. Thus, because of the mild or early dementia, sufficient cognitive ability is maintained for an awareness of their deficits and the consequences of those deficits. As dementia progresses in severity individuals subsequently experience a decrease in their cognitive capacities for this insight and awareness into their deficits, thus serving as a protection mechanism against depression. The results illustrated that the severity of the cognitive deficits and the insight of awareness of those cognitive deficits impact how depressive symptoms are reported and measured, and subsequently treated (Ott & Fogel).

Clare, Goater, and Woods (2006) investigated the coping methods of elderly individuals with early-stage dementia. Using the self-regulation model (SRM), five dimensions of cognitive coping strategies were measured: illness identity or label, cause, course or time-line, cures or controls, and consequences. The SRM has been used in understanding the wide range of coping strategies for people diagnosed with Addison’s Disease, chronic fatigue syndrome, multiple sclerosis, Huntington’s disease, coronary heart disease, and severe mental illness (Clare, et al., 2006). Through semi-structured interviews, participants’ responses were analyzed for content. The results illustrate that most participants did not view themselves as having an illness, such as a diagnosis of Alzheimer’s dementia but attributed the deficits to a normal part of aging. Half of the participants believed their cognitive abilities and difficulties were stable, and would not
worsen. The authors suggested that this observed denial of accepting one’s illness serves as a coping mechanism, safeguarding against societal attitudes and stigma of dementia and other related conditions with the elderly population. Understanding these psychosocial factors that affect the insight and awareness level of dementia is critical in developing interventions, treatments, and relationships with medical professionals (Clare, et al.)

**Strokes and Traumatic Brain Injuries (TBI)**

Strokes and traumatic brain injuries (TBI) are also conditions that impair insight and awareness (Fleminger, Oliver, Williams, & Evans, 2003). Up to 45% of individuals who suffered a moderate-to severe TBI have impaired insight (Boake, et al., as cited in Fleminger, et al.). Insight into one’s new limitations and disabilities, and the subsequent emotional distress, requires coping skills to engage successfully and meaningfully in day to day living. Awareness over the loss of vocational goals, recreational hobbies, and other pre-morbid levels of functioning and expectations can contribute to depression. The authors suggest that poor insight or denial of these limitations serves as a defense mechanism against depression and low self-esteem. However this denial may be short lived; as individuals attempt to engage in their pre-morbid lifestyle and activities without success, the negative consequences that result may force individuals into realistic evaluations, or even stronger denial. These negative appraisals and evaluations can create depression, accompanied also with a greater awareness and acceptance of these limitations.

Godfrey, Partridge, Knight, and Bishara (as cited Fleminger, et al., 2003) found that six months after a closed head injury, participants’ self-reports of their behavioral impairment, cognitive deficits, and emotional adjustment displayed impaired insight. The self-reports of the participants were then compared to a more objective assessment of a report of each participant’s
close relative. At this initial six months post-injury measurement, limited emotional dysfunction from the participants was reported. At the one, and two-three year follow ups, participants’ insight of their impairments and deficits increased, thus illustrating fewer discrepancies between the self-report and that by the close relative. With this higher level of reported insight, higher levels of depression and anxiety, as well as lower self-esteem were also observed. The authors explored this relationship between the increased insight and depression, and offered two different causality hypotheses: depression results from fostering greater insight or a state of depression produces this insight. Future studies investigating these proposed hypotheses were recommended.

**Impaired Insight among Mental Disorders**

Along with the medical conditions mentioned above, mental disorders, as outlined in the DSM-IV-TR, characterize various conditions that have been associated with impaired insight and awareness. Because insight has been demonstrated by previous research to be a predictor of clinical outcome for mental illnesses, a plethora of research exists investigating this topic (Yen, Chen, Lee et al., 2009).

**Bi-polar Disorder**

In a research study by Dias, Brissos, and Carita (2008), 60% of the participants diagnosed with bipolar I disorder demonstrated impaired insight. This finding is consistent with previous literature, finding that insight impairment is common among patients diagnosed with bipolar disorder. Previous literature on bipolar disorder has also illustrated an existence of state dependent insight, in which insight is most impaired during the manic phase of the bipolar disorder. As patients enter the depression phase of the disorder, insight increases (Dias, et al). However, Yen, Chen, Ko, Yen, and Huang (2007) investigated the change in insight among
participants diagnosed with bi-polar disorder over a two year period. They found that after a manic episode, the insight level returned to the pre-episode level for only patients that had experienced one manic episode. For the other participants who had experienced multiple manic episodes in the past, their insight level did not increase following a manic episode. Additionally, no changes in insight were illustrated in patients experiencing the depressive phase of the illness, regardless of the number of previous depressive phases (Yen, Chen, Ko, et al.).

Contradictory results also exist in regard to the influence of psychotic symptoms, present at times in bipolar disorder. Evidence exists illustrating that previous psychotic symptoms further impair insight and one’s ability to relabel symptoms (Yen et al. as cited in Dias, et al., 2008), in addition to evidence to suggest that previous psychotic symptoms do not impair insight (Dias, et al.).

These insight levels have been demonstrated to have significant impacts on treatment outcomes. Yen, Chen, Yang, et al. (2007) found that among participants diagnosed with bipolar disorder, insight, as measured by the SAI and SAI-E, was associated with higher levels of psychosocial functioning. Additionally, poorer psychosocial adjustment was associated with the presence of residual affective symptoms, characterized in mania and depression. The implication of these findings suggest changes and variations of treatment interventions aimed at increasing insight, depending on: phase of illnesses, frequency of past manic episodes, and previous psychotic symptoms (Yen, Chen, Yang, et al.).

**Schizophrenia**

One key characteristic and symptom of the disorder schizophrenia encompasses a general lack of awareness of having a mental disorder. Among individuals diagnosed with schizophrenia, 60% of patients demonstrated a moderate to severe lack of awareness (Schwartz,
This lack of insight or awareness is more prevalent than with any other mental disorder, including schizoaffective disorder or major depressive disorders with or without psychosis (Schwartz). Cooke, et al., (2007) investigated the insight levels of individuals diagnosed with psychosis and found that roughly 45% of participants’ scores on the insight measure were classified as having poor insight. In another study, the insight level of roughly 53% of participants diagnosed with schizophrenia fell into the poor insight level (McLeod, et al., 2009).

Further, highly stigmatized and stereotypic beliefs of schizophrenia are very prevalent in society. Thus, with understanding the observed high level of insight impairment among individuals diagnosed with schizophrenia, as well as the impact of the associated stigmatized and stereotypic implications, the high level of interest given to researching schizophrenia is warranted (Lysaker, France, et al., 2005). This research provides a context to investigate factors mediating the insight impairment and treatment outcome. Through this research, evaluating effective therapeutic interventions and treatments for schizophrenia becomes possible. From this investigation and understanding, the effectiveness of these interventions and treatments can be explored with individuals diagnosed with other mental disorders. Throughout this paper, attention will be given to research focused primarily on schizophrenia in an attempt to provide a foundational comprehension, with broader implications and applications for all disorders and conditions characterized with impaired insight.

**Individual research studies.** Research investigating insight among individuals diagnosed with schizophrenia has been inconsistent. Discrepancies exist in defining, and subsequently measuring, the phenomenon of insight. Schwartz (1998) explored the evolving perspective, produced by current research, of defining and documenting insight using multidimensional terms, rather than the previous categorical perspective. Insight defined as a
unitary construct was demonstrated to be insufficient, due to the many phenomena that comprise it (Schwartz). Currently, standardized and objective assessments and evaluations exist to measure insight, which allow for confirmatory duplication and replication of research results. Previous to this standardization, subjective, and biased assessments were used in an attempt to study insight in a general and broad term. This methodology led to contradictory findings, with an inability to confirm findings, and generalize results.

Mohamed et al. (2009) investigated the relationship between change in insight, medication adherence, clinical symptoms associated with schizophrenia, QOL, and depression over an eighteen month period of time among participants diagnosed with schizophrenia. Insight was assessed using the ITAQ, measuring the participants’ awareness of illness and insight into need for treatment. Mohamed et al. hypothesized in the current study, using cross-sectional methodology, that reduced psychopathology and better functioning capacity would be significantly associated with insight and attitudes toward medication. Additionally, the authors hypothesized that the level of insight and medication attitudes of participants at the onset of the study would serve as predictive factors for future psychopathology, social/occupational functioning, and treatment adherence, measured later in the study.

This study used a variety of dependent measures to investigate the effects of insight and drug attitudes, shown to be reliable and valid measures from previous research. For insight and drug attitudes, the ITAQ was administrated, as well as a true and false measure, the Drug Attitude Inventory (DAI). Researchers also measured the positive and negative symptoms of schizophrenia using the Positive and Negative Syndrome Scale (PANSS). The insight score of the PANSS was not included in the analysis to avoid redundancy. Depressive symptoms were measured using the Calgary Depression Rating Scale. The Heinrichs-Carpenter Quality of Life
Scale and the Lehman Quality of Life Interview was administered to measure psychosocial functioning and quality of life of the participants. Medication adherence was measured through structured questions at each appointment, monthly pill counts, and subjective evaluations from family and clinicians. The Barnes Akathisia Scale was used to measure akathisia, and tardive dyskinesia was measured using the Abnormal Involuntary Movement Scale. Finally, neurocognitive functioning was assessed on a five construct scale: processing speed, verbal memory, vigilance, reasoning, and working memory (Mohamed et al., 2009).

When analyzed from the data from a cross-sectional methodology at baseline the results demonstrated that insight, QOL, psychosocial functioning, medication attitudes, and performance on cognitive measures were significantly positively correlated to each other, as well as associated with lower schizophrenic symptoms. Thus those participants with higher levels of insight had a higher quality of life, better psychosocial functioning, had more positive attitudes toward medication, performed better on cognitive testing, and experienced fewer schizophrenic symptoms than those participants with lower levels of insight (Mohamed et al., 2009).

Additionally, at baseline, greater insight was also associated with more severe depressive symptoms. Due to the methodology, causality cannot be determined. The authors proposed that impaired insight could serve a defensive function, in an attempt to maintain self-esteem and positive appraisals, such that increased insight causes an increase in depressive symptoms because of the negative consequences. However, the direction of causality could be in the opposite direction, by which an increase in depressive symptoms produce an increase in insight. Following the cognitive model of the theory of depressive realism, the higher levels of depression may produce more accurate and realistic appraisals and evaluations, thus resulting in higher levels of insight (Mohamed et al., 2009).
The data was also analyzed using a longitudinal methodology using the measurements at baseline and seven follow-up appointments extending over an eighteen month period of time. The results illustrated that higher levels of insight at baseline were associated with lower schizophrenic symptoms. Participants with more positive medication attitudes at baseline displayed lower schizophrenic symptoms, and better community functioning. An increase in insight from baseline to follow-up was associated with lowered schizophrenic symptoms, improvement in QOL, and increased medication compliance. However, a change in insight from baseline to follow-up was also associated with increased levels of depression. An increase of positive medication attitudes from baseline to follow-up was associated with lowered schizophrenic symptoms and depressive symptoms, as well as an increase in QOL, and medication compliance, (Mohamed et al., 2009).

The rigorous methodology of this study, including the large sample size of 1,432 participants, longitudinal and cross sectional designs, randomization of participants, control of confounds, and a variety of dependent measures, all serve as strengths of this study. Previous research investigating the relationship of insight and medication attitudes has been inconsistent. This study thoroughly explored this relationship, as well as explored the relationship and possible explanations of the association between insight and depression. On a clinical level, this study serves as evidence to alter treatment includes an increased awareness to the noted increase in depressive symptoms as insight is increased. However, following the framework behind their use of insight assessment, the ITAQ, the researchers proposed that although insight involves multiple dimensions (e.g., general awareness and attitudes to treatment); the dimensions represent a single construct. This proposal contradicts current views on insight being composed of independent and interrelated components.
Karow et al. (2008) investigated the relationship between insight and QOL among patients diagnosed with schizophrenia. The researchers hypothesized that participants with greater self and expert rated level of insight into the disorder of schizophrenia will have lower scores of QOL. 59 patients were assessed during their first week of an in-patient treatment. Participants and clinicians rated the participants’ insight, using the Insight Scale (IS); and SUMD and PANSS insight item; respectively. Analysis of additional measures assessing the participants’ quality of life (MSQoL), confirmed their hypothesis, revealing significant associations between increased insight and lower scores on five of the QOL scales: physical health, vitality, psychosocial, affective, and general QOL. Additionally, participants who had attempted suicide before demonstrated higher levels of insight. Higher insight was also correlated with participants who had close relationships and social support, such as living with a partner. Further variables of age, gender, level of education, current job and living situation were not significantly associated with insight (Karow et al., 2008).

Several limitations exist in this study. Of the participants, 35% also had a co-morbid substance misuse of either alcohol, cannabis, or a combination of multiple drugs. Because of this substance misuse, the dependent measures could have been uncontrollably influenced. Despite the limitations, this study adequately measured insight using a variety of assessments conceptualizing its multi dimensions. The implications of this study suggest with increased insight, poorer QOL and risk of suicidality are increased (Karow et al., 2008). These findings encourage further research in investigating additional psychosocial factors that can serve as protective factors, lessening the decrease in QOL, as insight is increased in therapy.

**Meta-analysis.** A meta-analysis by Mintz (as cited in Cooke, et al., 2007) illustrated a modest relationship between insight and depressive symptoms among patients with psychosis.
Thus, higher levels of insight are associated with more depressive symptoms. Among patients diagnosed with schizophrenia, insight impairment was demonstrated to vary across the illness course, with greater impairment during the acute phase of the schizophrenic illness. The occurrence of positive symptoms during this acute phase also increases the risk of insight impairment. Amador (as cited in Lewis, 2004) added further understanding of the observed insight impairment in the acute phase of the illness, hypothesizing that partial but incomplete insight creates the highest risk for negative outcomes, because as patients begin to understand they have a disorder they make inaccurate self-attributions in understanding their symptoms (e.g., “This means I am a hopeless loser.”).

In an earlier analysis, May (1984, as cited in Martens, 2009) analyzed 40 controlled studies among individuals diagnosed with schizophrenia and found that too much and too swift uncovering of insight and awareness is harmful for some individuals. The implications of this research suggest a change in the treatment programming and therapeutic process for individuals diagnosed with schizophrenia.

**Postpsychotic depression (PPD).** Often, as documented in previous research by Iqbal et al. and Birchwood, Iqbal, Chadwick, and Trower (as cited in Lewis, 2004), depression can follow an acute phase of psychosis, at times in the form of postpsychotic depression (PPD). Of the research participants, 70% of patients diagnosed with schizophrenia experienced depression, and 36% of those participants developed PPD. Surprisingly, the insight level was not significantly different among the patients who did not experience depression, those that experienced depression, and those that experienced PPD before the onset of any psychosis. However, of those participants that experienced PPD, internal and stable characteristics of themselves and their disorder were observed (e.g., they thought they were the cause of their
psychosis and/or they were powerless to change their inferior social status due to their disorder). Upon measuring insight and self-appraisals of the research participants after the occurrence of depression, the participants that experienced PPD illustrated higher levels of insight and awareness, and more negative self-appraisals when compared to the other participants (Lewis, 2004).

Thus, Lewis (2004) contends that insight impairment alone does not predict the occurrence of depression and/or PDD, since no differences of insight level were reported among the group, yet not all the participants experienced depression. Of those that did experience depression or PDD, the influences of the participants’ self-appraisals and levels of hopefulness and pessimism led to these depressive outcomes.

**Suicidality.** Associated with the occurrence of depressive symptoms is also the increased risk of suicide. Of the participants that experienced PPD, more than half of those participants reported suicide ideation, with 4% making a serious suicide attempt (Iqbal et al., and Birchwood, Iqbal, Chadwick, and Trower, as cited in Lewis, 2004) Therefore, understanding the risk factors of treatment outcomes in regard to depression is also pertinent in understanding and assessing suicidality. By identifying factors that contribute and mediate the occurrence of depression, clinicians can therefore intervene appropriately in regards to suicide. Without proper understanding and assessment, patients diagnosed with schizophrenia at a heightened risk for depression and suicide may not receive adequate treatment (Lewis, 2004; Martens, 2009).

**Insight and Cognitive Functioning In Mental Disorders**

Research has indicated evidence that insight impairment observed among patients diagnosed with mental disorders may be a result of neurocognitive impairment, primarily the executive function (Lewis, 2004; Yen, Cheng, et al., 2009). The implications of this hypothesis
are significant. If insight impairment is caused by neurocognitive impairment, such as in anosognosia, increasing insight in psychotherapy may be limited or impossible. Anosognosia is a neurological symptom caused by dysfunction or damage to the frontal or parietal lobes, which disable an individual from engaging and sustaining the cognitive processes required for creating insight and awareness (Lewis).

This theory runs contrary to the hypothesis that impaired insight serves a functional role in protecting one’s self-esteem from negative evaluations and appraisals associated with accepting and accurately identifying one’s diagnosed disorder. From a psychoanalytic perspective, denial consists of an unconscious psychological defense mechanism to defend against psychic pain caused from accepting one’s illness and the consequences of that illness (Lewis, 2004).

Additionally, neurocognitive deficits that lack generalizability from one mental disorder to another would require neurocognitive testing for each subsequent mental disorder. If, for example, neurocognitive functioning is illustrated to be responsible for the insight impairment observed in patients diagnosed with schizophrenia, this finding may or may not be accurate in explaining the insight impairment among patients diagnosed with depression or bipolar depression (Lewis, 2004).

Because ethically demonstrating causality is difficult, and nearly impossible, a correlation between neurocognitive impairment and impaired insight has been attempted to be demonstrated in research. To illustrate this correlation, a significant number of patients, greater than the number due to chance, would need to demonstrate similar insight and neurocognitive impairment.
Inconsistent Individual Research Studies

Research on the relationship between neurocognitive impairment and insight has been inconsistent. Some studies have found that poorer insight has been associated with lower executive function and IQ, while some studies have not supported this relationship (Cooke, et al., 2007). Mohamed et al. (as cited in Lewis, 2004) found that unawareness and misattribution of negative symptoms were associated to executive function deficits, located in the frontal lobe. Startup (as cited in Cooke et al.) found that both high and low extremes of insight were associated with high cognitive ability, suggesting a curvilinear relationship. Because of the curvilinear relationship, cognitive ability was not illustrated to be associated with insight impairment.

However, the various methodologies used in assessing insight, and analyzing insight as a total score or a variety of sub scores contributes to this inconsistency. Additionally, the wide range of neurocognitive tests and assessments used in the previous research also contributes to the inconsistencies. As mentioned earlier in this paper, insight conceptualized as a singular concept and analyzed in regard to neurocognitive functioning may or may not produce similar results if insight is conceptualized as a multifaceted categorical construct, and analyzed using scores from each dimension.

Executive function. Further investigation of the relationship among insight, neurocognitive dysfunction, and schizophrenic symptoms include the research of Monterio, Silva, and Louza (2008). 40 participants diagnosed with chronic schizophrenia were assessed using: the PANSS, measuring positive and negative symptoms; neurocognitive assessments, such as the Wisconsin Card Sorting Test (WCST); as well as undergoing an assessment to measure insight and awareness using the SUMD.
Results illustrated that three specific aspects within the SUMD, including the past, and current awareness of symptoms, as well as the awareness of perception for symptoms were positively correlated with WCST correct answers, and non-persevering errors. These results are consistent with previous literature, highlighting a relationship between impaired insight and impaired executive function, as measured by the WCST. The researchers also controlled for the various types of antipsychotic medicines the participants were taking. No significant differences were found among the measures between the two groups (Monterio, et al., 2008).

The strengths of this study consist of the mentioned above control for differing medications that could impact the presence of positive and negative symptoms, as well as alter the results of the SUMD and the neurocognitive tasks. By providing thorough explanations of the findings, this study provides further evidence illustrating the mechanisms behind how insight and cognitive functioning may be related.

Yen, Cheng, et al. (2009) also investigated the influence the impaired insight and psychosocial adjustment of participants engaged in outpatient treatment who were diagnosed with schizophrenia or bipolar disorders. The researchers investigated the relationship between this impaired insight and its relationship with the presence of any executive functioning impairment. The researchers hypothesized that executive functioning and psychosocial adjustment would be positively correlated, and that participants’ insight level would have a mediating or moderating effect on the outcome variable of psychosocial adjustment.

A total of 96 participants diagnosed with schizophrenia, and 96 participants diagnosed with bipolar depression from two outpatient hospitals in Taiwan were measured in this study. Various measures were used including, the Community Life Scale (CLS), the Schedule of Assessment of Insight-Expanded version (SAI-E), and tests to assess executive functioning, such
as the Wisconsin Card Sorting Test (WCST). The results of this study illustrated that for participants diagnosed with schizophrenia, insight was positively associated with psychosocial adjustment, however this relationship was not found among participants diagnosed with bipolar depression. In regard to executive function for participants diagnosed with schizophrenia and bipolar disorder, executive function was positively correlated with insight. Additionally executive function was also positively associated with psychosocial adjustment for both groups of participants (Yen, Cheng, et al., 2009).

The authors highlighted the importance of executive functioning in planning and executing complex behaviors in daily living. They advised including neurocognitive–enhancing treatments in treatment programs for patients diagnosed with schizophrenia and bipolar disorder, thus increasing the likelihood of increasing insight and psychosocial adjustment. However, for participants diagnosed with schizophrenia, insight was demonstrated to have a mediating influence on the relationship between executive function and psychosocial adjustment. This relationship was not observed among patients diagnosed with bipolar depression, thus indicating that insight has varying influences on treatment outcomes in different mental disorders (Yen, Cheng, et al., 2009).

This study consists of participants diagnosed with schizophrenia and bipolar depression in remission; therefore the results limit generalizability to the greater scope of patients not in remission. Insight was measured using the SAI-E, assessing multiple dimensions of insight, including: compliance with treatment, recognition of illness, relabeling of psychotic phenomena, and awareness of changes in mental functioning and psychosocial consequences. However, the insight score was analyzed as a single score, rather than the subscales, thus limiting understanding of relationships among the subsequent insight dimensions. Further this study
explored the possible mediating or moderating influence of insight; illustrating a mediating effect among patients diagnosed with schizophrenia, contributing to the body of knowledge on this subject (Yen, Cheng, et al., 2009).

**Attention and mental control, executive function, fluency, and logical memory.**

Dias, Brissos, and Carita (2008) also investigated the relationship between insight and neurocognition among participants diagnosed with bipolar I disorder in remission. Insight was assessed using the SUMD, measuring the participants’ current awareness of mental disorder, social consequences of the disorder, and effects of the medication. After the analysis, two thirds of the participants diagnosed with bipolar disorder demonstrated impaired insight. A battery of neurocognitive functioning was used, assessing: attention and mental control; perceptual-motor skills; executive functions; verbal fluency; verbal abstraction; comprehension; visuospatial attention; and memory function.

When the neurocognitive results of participants diagnosed with bipolar disorder were analyzed, the Trail Making Test Part B (TMT-B), measuring executive function; the Symbol Digit Modalities Test (SDMT) measuring perceptual-motor skills; the Controlled Oral Word Association (COWA) measuring fluency; and the WAIS-R subtest, measuring logical memory, were significantly worse than the neurocognitive results of the control participants. In the relationship between insight and neurocognitive tests among participants diagnosed with bipolar disorder, impairments on the Digit Span, measuring attention and mental control; the TMT-B, measuring executive function; the COWA, measuring verbal fluency; and the WAIS-R subtest of logical memory were associated with impaired insight on all dimensions. Thus the authors propose that these affected neurocognitive processes and mechanisms are involved in creating
insight, suggesting that the prefrontal lobe function partially determines an individual’s ability for insight among patients diagnosed with bipolar disorder (Dias, et al., 2008).

**Symptom misattribution and executive function.** Smith, Hull, Israel, and Willson (2000) investigated the frontal and parietal lobe functioning among patients diagnosed with schizophrenia. The authors highlighted the previous research suggesting the insight impairment observed among patients diagnosed with schizophrenia resembles the syndrome of anosognosia: dysfunction or damage in parietal lobe and/or frontal lobe functioning. Frontal lobe functioning impairment among patients diagnosed with schizophrenia is supported by research demonstrating participants’ poor performance on card sorting tests (e.g., Wisconsin Card Sorting Test (WSCT)), which requires executive function processes (Smith, et al.).

Unexpected results occurred in regard to insight impairment rating from the SUMD assessment. The analysis indicated that participants had unusually low levels of unawareness of having a disorder, unawareness of the effects of medication, and unawareness of the social consequences of the disorder, thereby categorizing over 50% of the research participants as most aware. Because of this skewed data, results of the SUMD assessment were not used. Two measures of insight from different assessments were analyzed, consisting of overall symptom unawareness and misattribution variables. Symptom unawareness was not related to neurocognitive cognitive functioning, as measured from a battery of assessments measuring: early visual processing, memory, frontal love/executive functioning, and parietal love/visuo-spatial functioning. Symptom unawareness was influenced by the positive, negative, thought disorder, and depression categories of symptom dimensions. However, the other measure of insight, symptom misattribution, was associated with executive functioning in the frontal lobe, as
measured in the participants’ performance on the WCST. In regard to depression, depression was correlated with lower levels of unawareness (i.e., higher awareness) (Smith, et al., 2000).

The results of this study provide further evidence that insight is a complex and multifaceted construct, in which neurocognitive impairment affects select aspects of insight. Neurocognitive impairments in frontal lobe functioning among individuals diagnosed with schizophrenia appear to play a significant role in symptom misattribution. The authors suggest contradictory research finding no relationship between insight and symptoms can be explained from the methodology used of defining insight as a single construct. By defining insight as a single construct, the different aspects and relationships to neurocognitive functioning will not be adequately demonstrated, and subsequent relationships could be washed out. The unexpected insight impairment analysis measured by the SUMD provides further evidence to the discrepancies in assessments producing contradictory findings. From the SUMD ratings, over half of the participants were categorized as most aware. However, the rating of the participants’ overall symptom unawareness and misattribution variables demonstrated insight impairment. Thus convincing evidence supports the hypothesis that the SUMD assessments of awareness of having a mental disorder, awareness of the effects of medication, and unawareness of the social consequences of the disorder measures different aspects of insight required in an awareness of having and properly attributing specific symptoms (Smith, et al., 2000).

**Meta-Analysis**

Aleman, Agrawal, Morgan, and David (2006) conducted a meta-analysis reviewing the relationship between insight ratings and cognitive functioning on various domains. The data was analyzed from patients diagnosed with schizophrenia and other psychotic disorders. Previous research has illustrated the effects of impaired insight on poorer treatment outcome, and global
functioning. Inconsistent results exist for exploring and understanding the relationship between insight and neurocognitive functioning, measured by general intelligence, as well as through subdomains, such as frontal executive functioning. This present study integrated 35 studies, composed of 2,354 participants, and computed effect sizes for each study and analyzed a combined effect size.

The results of this study illustrated that insight is significantly positively associated with general cognitive functioning. For patients diagnosed with psychotic disorders in general, the association between insight and frontal executive functioning, as measured by the Wisconsin Card Sorting Test (WCST), was stronger than the association between insight and general intelligence. However, when analyzed only for patients diagnosed with schizophrenia, this association was not significantly stronger than the association between insight and general intelligence. Additionally, limited only to schizophrenic patients, memory performance and insight was significantly correlated. These results provide further illustration of the importance of cognitive flexibility and perseveration of errors, as tested by the WCST in leading to insight deficits, as well as the pervasiveness of cognitive deficits characterized in schizophrenia as compared to psychotic disorders in general (Aleman, et al., 2006).

In summary, the previous research illustrates that neurocognitive deficits do impact one’s ability to create and maintain insight, accomplished through the executive function, however, these neurocognitive impairments are not sufficient, alone, in explaining impaired insight among individuals diagnosed with mental disorders. Cuesta and Peralta (1995); Kemp and David (1996); Kim, Jayathilake, and Meltzer (2003) (as cited in Lysaker, France, et al., 2005) found that insight into one’s illness was not associated to cognition. Thus, Startup (1996, as cited in Lysaker, France, et al.) suggested that neurocognitive deficits should be integrated with the view
that impaired insight serves an adaptive and defensive coping response. Thus, greater understanding and synthesis can be accomplished through an awareness of the impact of an individual’s neurocognitive functioning impairment, as well as the adaptive function impaired insight plays for individuals diagnosed with mental disorders (Lysaker, France, et al.)

**Factors that Influence Insight and Treatment Outcome**

Previous research has illustrated the various discrepancies and inconsistencies among the studies investigating the relationship between insight and depressive symptoms. Additional research suggests that these inconsistencies can be explained by the presence of additional factors that influence how the insight is perceived, thereby resulting in different treatment outcomes. Referring to the research previously mentioned by Iqbal et al. and Birchwood, Iqbal, Chadwick, and Trower (as cited in Lewis, 2004) insight levels among patients diagnosed with schizophrenia did not accurately predict the later occurrence of depression. Among the participants, no differences of insight impairment were observed, yet only 70% of those participants later experienced depression. Hence, without the investigation of these additional factors that influence treatment outcomes, understanding the effect of insight and its paradoxical effect will not be adequate. Insight alone does not sufficiently predict treatment outcomes, measured in the client’s presence of symptoms, psychosocial functioning, depression, anxiety, and suicidality. Other factors, such as self-esteem, hopelessness, and stigmatization further affect how this increased insight and awareness of the diagnosed disorder is perceived by the client, thereby influencing the client’s perceptions of his or her future, expectations, competencies, and ability to recover (Lysaker, France, et al., 2005).
Coping Styles in Patients with TBI

Fleminger, et al. (2003), further investigated psychosocial factors that contribute to and intensify this observed depression among patients with TBI. Following grief models and stress-coping theories, acceptance of loss, adjustment and reintegration to successfully master the demands of life, influence the rise of depression symptoms. Thus it is not simply insight into one’s deficits and limitations that cause depression, but the development of unhelpful coping styles to adjust to these deficits and limitations that produce feels of inadequacy, hopelessness and subsequent depressive symptoms. Finset and Anderson (as cited in Fleminger, et al.) investigated the differences in coping between participants with an acquired brain injury (ABI), and a control group, and found that the ABI participants had a less differentiated coping style. Avoidant coping was associated with depression, and a lack of active-approach coping was associated with apathy. Thus these results demonstrate the need for approach coping skill training in recovery and therapy in order for individuals to adequately adjust to the negative appraisals created by their insight and awareness. Failure to provide these tools and techniques leaves individuals in a state of helplessness, where by remaining in denial of their deficits is more favorable than realizing their deficits and not being able to adequately cope with them (Fleminger, et al.).

Coping Styles, Hope, and Stigma

Lysaker, Salyers, Tsai, Spurrier, and Davis (2008) investigated the associations between hope, stigma, clinical symptoms, anxiety, and coping preferences among patients diagnosed with schizophrenia spectrum disorders. Because hope has been illustrated to significantly impact treatment outcomes of individuals with mental illnesses, such as social and vocational dysfunction, as well as predict the risk of suicidality, understanding how hope is fostered and
persevered is essential for implementing effective recovery programs. As measured using the BHS, participants are asked to endorse 20 statements as true or false as each statement best applies to them. From these statements, the researchers constructed two categories of hope: expectations of the future, and motivational hope. Expectations of the future characterize the participants’ beliefs of future success and/or frustration, whereas motivational hope illustrates the participants’ beliefs and expectations of their ability to meaningfully affect their future, similar to the term agency (Lysaker, Salyers, et al.).

Using the Ways of Coping Questionnaire (WCQ), the participants’ identified stressors and rated how often they used behaviors to cope with that stressor. Two, ignoring and resigning, of the six modes of coping were used in the analysis. These two domains were selected because they characterize avoidant approaches, as compared to the other more active and problem-focused coping behaviors. Ignoring refers to the coping behavior of choosing not to think about the stressor. Resigning illustrates the coping behavior of choosing not to act because the participant believes nothing can be done to change the situation. Additionally, participants positive, negative, and emotional discomfort components were analyzed from the PANSS. The PANSS assessment includes a semi structured interview in which the researcher rates 30 items (Lysaker, Salyers, et al., 2008).

The level of anxiety was measuring using the Multidimensional Anxiety Questionnaire (MAQ), analyzing their physiological-panic (i.e., physiological symptoms of anxiety and anticipation of panic), social phobia (i.e., worries about social embarrassment and social avoidance), and worry-fears (i.e., general experiences of worry and fearfulness of daily life). The MAQ is accomplished through a 40-item self-report questionnaire. Finally, this study measured participants’ subjective experience of stigma, using The Internalizing Stigma of
Mental Illness Scale (ISMIS), which consists of 29 statements rated by the participant on a 4-point Likert scale of how much they agree or disagree with the statement. Three of the five subscales of the assessment were used in the analysis: alienation (i.e., feeling devalued as a member of society), stereotype endorsement (i.e., agreement with negative stereotypes of mental illness), discrimination experience (i.e., current mistreatment attributed to the biases of others) (Lysaker, Salyers, et al., 2008).

The results of this study unfolded a variety of factors and relationships that influence the recovery and treatment outcome. In regard to hope, both participants’ expectations of the success in the future and their expectations to affect change, were association with lower levels of stigma, fewer symptoms, lesser anxiety, and lower use of avoidant coping behaviors. These hope scores were unrelated to the age, sex, education, or diagnosis (i.e., schizophrenia compared to schizoaffective disorder), thus illustrating an ability to generalize these results to various individuals within the schizophrenia spectrum community. Specifically, the participants’ level of alienation, a subscale of stigma, was most related to the hope domain of expectations of the future. Hence, participants who felt more valued as a member of society had higher expectations of success in the future (Lysaker, Salyers, et al., 2008). The stereotyped endorsement of stigma was most related to the other hope domain of expectations of ability to change (i.e., agency). Hence, participants who rejected the negative stereotypes of mental illness had higher expectations of their ability to impact and affect their future. The hope domain of expectations of one’s ability to change (i.e., agency) was associated to stigma, symptoms, anxiety, and avoidant coping. The hope domain of expectations of the future was associated to stigma, symptoms, and avoidant coping (Lysaker, Salyers, et al., 2008).
A variety of possible hypotheses exist in explaining these results. Different aspects of stigma could be related to different domains of hope, whereas participants’ endorsements of stereotypes of mental illness cause a decrease in their sense of agency because these stereotypes of mental illness promote a lack of ability to overcome one’s diagnosis. However, another possible hypothesis could be that participants with lower levels of hope, expectations of the future, and motivational hope, are more susceptible to believe and accept the stigma associated to mental disorders, thus increasing anxiety, avoidant coping, and clinical symptoms (Lysaker, Salyers, et al., 2008).

Although this study did not measure participants’ level of insight impairment, it did investigate factors, such as hope and stigmatized beliefs, which impact the perception of one’s insight. Insight into one’s awareness of being diagnosed with a mental disorder, appropriate attribution of symptoms to the disorder, acknowledgement of the need for treatment, adequate awareness of specific signs and symptoms of the disorder, and an understanding of the social consequences of the disorder are all impacted by one’s level of hope, in both expectations of the future, and motivational hope (Lysaker, Salyers, et al., 2008). An individual may be more or less likely to proceed with treatment increasing insight, if his or her level of hope is maintained throughout the process. Similarly in regard to stigma, fostered insight will be perceived differently to the extent to which an individual internalizes stereotypic beliefs of mental illness, and feels devalued as a member of society. Thus effective treatment in the recovery of mental illness needs to address how the treatment influences the patients’ level of hope, as well as the patients’ internal stigmatized beliefs. As illustrated by this study, maintaining hope, and rejecting stigmatized beliefs of mental illness is essential for successfully recovery (Lysaker, Salyers, et al., 2008).
Stigma, Hope, Self-Esteem, and Insight

Similarly, Yanos, Roe, Markus and Lysaker (2008) explored the effects of internalized stigma on hopelessness, and self-esteem. Previous research has demonstrated the commonality of internalized stigma regarding mental disorders among individuals diagnosed with a mental disorder. The presence of internalized stigma has been negatively correlated with hopefulness and self-esteem. The researchers hypothesized that a person’s insight and awareness related to the disorder is influenced by the attitudes, beliefs, and meanings the person attaches to the diagnosis. Thus because of the internalization of stigma, once a person has gained insight into one’s diagnosis, his or her self-esteem and hopefulness decrease because of the negative meanings attached to the stigmatized disorder. These stigmatized beliefs and expectations, and subsequent lowered self-esteem and hopefulness, thereby create a self-fulfilling prophecy in which the person plays out, demonstrated in poor treatment adherence, low social interaction, and avoidant coping behaviors. These behaviors further hinder the person’s recovery, and lead to an increase in clinical symptoms and severity (Yanos, Roe, et al., 2008).

Awareness was measured using The Scale for Assessing Unawareness of Mental Disorder (SUMD), consisting of a three item rating from 1 to 5 by a researcher following a semi-structured interview. The total sum score is made up of the three items: the patient’s awareness of mental disorder, awareness of the consequences of mental disorder, and awareness of the effects of medication. Internalized stigma was measured using the Internalized Stigma of Mental Illness Scale (ISMIS), combining the participants’ alienation and stereotype endorsement scores into one total stigma score. The PANSS was analyzed according to three subgroups: depression, social avoidance, and positive symptoms. Using the Beck Hopelessness Scale (BHS), hopelessness was measured, as well as the usage of ignoring and resigning avoidant coping
behaviors measured by the Ways of Coping Questionnaire (WCQ). Finally, self-esteem was assessed using the Rosenberg Self-Esteem Scale (RSES), a self-report consisting of 10 items (Yanos, Roe, et al., 2008).

The results of this study illustrated that awareness was associated with the depression subscale of the PANSS, such that participants with higher levels of awareness of one’s mental disorder, consequences of mental disorder, and the effects of medication, had higher levels of depression symptoms. Hope and self-esteem were moderately correlated and were combined into one factor. This hope and self-esteem factor was found to be negatively correlated with avoidant coping, social avoidance, depressive symptoms, positive symptoms, and internal stigma. Internalized stigma was correlated to avoidant coping, social avoidance, and positive symptoms, and negatively associated with hope and self-esteem. The results of the study supported the researchers’ hypothesis that internalized stigma lowers individual’s self-esteem and hope, thereby increasing depressive symptoms, social avoidance, and avoidant coping. Because of the presence of these outcomes, treatment recovery is hindered. Thus this study provides further evidence in additional factors, hope, self-esteem, and internalized stigma that play an influential role in treatment outcome (Yanos, Roe, et al., 2008).

**Combinations of Insight and Stigma**

Lysaker, Roe, and Yanos (2007) further explored this observed paradox of insight, in which awareness of one’s mental disorder is associated with better treatment outcomes, and lesser self-esteem and hope. Researchers separated participants diagnosed with schizophrenia on their levels of insight and internalized stigma, assessed using the insight/judgment score of the PANSS and the ISMIS, respectively. Three groups were created by the analysis: low insight/mild stigma, high insight/minimal stigma, and high insight/moderate stigma. Hence the low
insight/mild stigma group consisted of participants who endorsed stigmatizing beliefs about mental illness, but did not have insight or awareness of their diagnosed mental illness. The high insight/minimal stigma group was composed of participants who did not endorse the stigmatizing beliefs about mental illness, and believed they did have a mental illness. Finally, the high insight/moderate stigma group consisted of participants who held stigmatizing beliefs about mental illness, and believed they had a mental illness (Lysaker, Roe, et al.).

Levels of hopefulness, self-esteem, and social function among the three groups were measured. Previous research (Lysaker, Campbell, & Johannesen, 2005, as cited in Lysaker, Roe et al., 2007) illustrated that one’s level of hopefulness, accompanied by a high level of insight, predicts problem-oriented coping, as well as assesses one’s view of the future. Hopefulness was measured using the BHS. Self-esteem has been demonstrated through previous research to predict life satisfaction and treatment outcome among participants diagnosed with schizophrenia (Bradshaw, & Brekke, 1999; Markowitz, 1999; Roe, 2003, as cited in Lysaker, Roe et al.). The Multidimensional Self-Esteem Inventory (MSEI) is an assessment that measures the participants’ self-perception of their overall social value. On a 5-point scale, participants rate each statement, 116 statements, to the degree it applies to them. Social function, as described by one’s capacity for interpersonal relationships, is a common impairment among patients diagnosed with schizophrenia. Social function was assessed using the Quality of Life Scale (QOLS), analyzing the interpersonal relations (i.e., frequency of recent social contacts), and intrapsychic foundations (i.e., qualitative aspects of interpersonal relationships) subscales (Lysaker, Roe, et al.). Thus hopefulness, self-esteem, and social function serve as appropriate dependent measures assessing treatment outcome (Lysaker, Roe, et al.).
The researchers hypothesized differences in these measures among the three different insight/stigma groups. They predicted the participants in the high insight/minimal stigma and the low insight/mild stigma groups would have higher levels of hope and self-esteem. Additionally, they predicted that the participants in the high insight/minimal stigma would have the highest level of social function when compared to the other two groups. The high insight/moderate stigma participants, because of their lowered self-esteem and hopefulness, social function would be impaired. Social function would also be impaired in the low insight/mild stigma group because of the participants’ inadequate and poor social adaptation due to their impaired insight (Lysaker, Roe, et al., 2007).

The results of this study supported the predictions of the three groups of low insight/mild stigma, high insight/minimal stigma, and high insight/moderate stigma, and the predicted effects on self-esteem, hopefulness, and social function. Additionally, the high insight/minimal stigma group when compared to the other two groups had significantly lower levels of positive and negative symptoms. However, an unexpected result consisted of the finding that the social function of the low insight/mild stigma group did not differ from the social function of the high insight/moderate stigma group. This finding suggests that social isolation may result from acceptance of stigma or unawareness of illness, or on the other hand, may be accounted for by neurocognitive impairment (Lysaker, Roe, et al., 2007).

**Suicidality**

This research on the high level of hopelessness observed among the participants in the high insight/moderate stigma group, have various therapeutic implications (Lysaker, Roe, et al., 2007). In addition to depressive symptoms, hopelessness is a risk factor for suicidality (Lewis, 2004). Wilson and Amador (2007, as cited in Martens, 2009) found that increased insight
producing an increase in hopelessness was linked to increased suicide risk. However, if the increased risk did not lead to an increase in hopelessness, then this insight was not associated with an increased suicide risk. Wilson and Amador (2007, as cited in Martens) also found that the level of hopelessness experienced was related to the individual’s pre-morbid functioning level, finding that the greater the decline in functioning, the greater severity of hopelessness. In comparison to other suicide risk factors, Lester (2007, as cited in Martens) found that hopelessness served the strongest predictor of suicide.

Thus this research advocates for clinicians’ careful and purposeful awareness of assessing suicide risk when aiming at increasing the insight of clients. Without understanding the dynamic relationships among insight, depressive symptoms, hopelessness, and suicidality clinicians can fail to provide effective and ethical treatment to clients.

**Executive Function**

To investigate the possible impact of cognitive deficits among participants diagnosed with schizophrenia and schizoaffective disorder in regard to social function and attributional style, Lysaker, Lancaster, Nees, and Davis (2004) included neurological assessments. Previous research has illustrated executive functioning impairment among patients diagnosed with schizophrenia. The Wisconsin Card Sorting Test (WCST), measures this domain by asking participants to match cards to a designated key card. However, the participants are not told the matching principle. After ten correct responses, the matching principle changes. The total number of categories correct was reported for each participant. To measure each participant’s knowledge of vocabulary, the subtest of the Weschler Adult Intelligence Scale III (WAIS-III) was used. This brief assessment measures the general verbal intellectual function of the participants. Previous research demonstrated that general verbal intellectual function is an aspect
of cognitive function that is less impacted in individuals diagnosed with schizophrenia (Lysaker, Lancaster, et al., 2004).

To measure attributional style, The Attributional Style Questionnaire (ASQ) was used, consisting of 12 different hypothetical life events. Participants rate, on a 7-point Likert scale, the extent to which they would attribute these events, six negative and six positive, to internal, stable, and global causes. Using the Quality of Life Scale (QOLS), the interpersonal relations, intrapsychic foundations, and common objects and activities (i.e., common community activities and possession of related objects), were analyzed to measure quality of life. Five components from the PANSS, positive, negative, cognitive, excitement, and emotional discomfort, were analyzed to measure clinical symptoms (Lysaker, Lancaster, et al., 2004).

The results illustrated that independent of other factors, such as cognitive impairment, symptoms and attributional style are associated to social function. Hence, lesser levels of negative symptoms and higher degrees of stable attributions predicted better social functioning on all three of the QOL categories. These results suggest that participants diagnosed with schizophrenia who believe life events are precipitated by predictable and stable causes, and display lower levels of negative symptoms (e.g., passive social withdrawal, blunted affect, emotional withdrawal, and poor rapport), have more frequent interpersonal contacts, higher qualitative aspects (e.g., empathy for others), and more community participation and objects or related memorabilia. These results suggest the importance and influencing role attribution style has on treatment outcomes (e.g., social function, and clinical symptoms). Similar to other research, results indicated that better cognitive function predicted better social function (Lysaker, Lancaster, et al., 2004).
Insight and Depression

Cooke, et al. (2007) investigated the influence of self-esteem on the observed association between increased insight and increased depression among participants diagnosed with psychotic disorders. Insight, measured from the Insight Scale, a self-report, assessed participants’ awareness of illness, awareness of symptoms, and awareness of the need for treatment. PANSS was used to assess positive, negative, and general symptoms, as well as insight in the single item question. IQ was measured using the Quick Test (Ammons & Ammons, as cited in Cooke, et al.), which consists of a picture vocabulary test of 50 items. Self-esteem was assessed using the Rosenberg Self-Esteem Scale, a ten item self-report. Finally, depressive symptoms were measured using the Beck Depression Inventory (BDI).

The results demonstrated that higher insight, as measured through the self-report, was associated with higher IQ, and poorer self-esteem, but not depression. After controlling for depressive symptoms, the relationship between insight and self-esteem, and the relationship between insight and IQ remained. Poor self-esteem has been linked to social anxiety in previous research. Among participants diagnosed with schizophrenia or schizoaffective disorder, low self-esteem rating predicted social anxiety six months later (Lysaker, Ringer, & Davis, 2008). Surprisingly, the clinician reported, single-item of insight from the PANSS was not associated with self-esteem or depression. These results add further evidence supporting that how researchers measure the complex construct of insight affects the results of correlations to dependent measures, as demonstrated with IQ and self-esteem (Cooke, et al., 2007).

A curvilinear relationship between self-reported insight and IQ was also observed, in which high IQ is associated with low and high insight scores. The authors suggest that cognitive ability influences insight, but is not sufficient on its own in producing good insight. As a way of
coping, individuals diagnosed with psychosis may manifest poor insight to promote and maintain positive self-evaluations. This theory is supported by the research, illustrating higher insight scores correspond with lower self-esteem. Thus this research further supports the complexity of the relationship between insight and treatment outcomes, such as depression, and proposes the investigation of further variables and factors that influence how individuals cope with insight into their diagnosed disorder. The researchers suggest a possible relationship between insight and stable, core beliefs about one’s self-worth (Cooke, et al., 2007).

Social Rank

Social rank may also have an influencing factor on the impairment of insight (McLeod, et al., 2009). The appraisals of social rank of participants diagnosed with schizophrenia were measured using the Social Comparison Scale (SCS), an eleven item self-report in which participants rate bipolar constructs (e.g., inferior-superior). Each participant completed the questionnaire twice, once comparing themselves to the general population, and once comparing themselves to their mental health worker. Insight was measured using a self-report insight scale, measuring three components: awareness of illness, attribution of symptoms to illness, and recognition of the need for treatment (McLeod, et al.).

Analysis of the data demonstrated a negative correlation between the total insight score and SCS comparisons for both the general population and each participant’s individual mental health worker. The SCS rankings to the mental health worker were lower than comparisons to the general population. Additionally, there was a negative correlation between illness awareness, a subscale of the insight assessment, and SCS comparisons made to the general population. However, this relationship of illness awareness was not observed to the SCS comparisons made
to each participant’s mental health worker, suggesting that insight is a multi-faceted construct that is impacted differently depending on other variables (McLeod, et al., 2009).

Implications of these results may aid further understanding of the association between insight and depression since studies have illustrated a link between rank appraisal and depressive symptoms. Social rank comparisons, therefore, appear to be a factor influencing the effects of insight, and treatment outcomes. The authors highlight the need for therapeutic intervention, which increases insight, to also target and improve patients’ negative social rank appraisals to prevent further dysfunctional consequences (McLeod, et al., 2009).

Another study investigated the differences in QOL, insight, self-stigma, and adverse effects of medication between participants diagnosed with depressive disorders and control participants (Yen, Chen, Lee, et al., 2009). The results demonstrated that participants diagnosed with depressive disorders had poorer QOL on three of the four domains: physical, psychological, and social relationship, when compared to the QOL of the control group. Additionally, among the participants diagnosed with depressive disorders, higher levels of self-stigma were correlated with poorer QOL. The researchers suggest that internalized stigma after accepting one’s diagnosis alters the individual’s expectations, beliefs, and goals of his or her future. Thus these negative appraisals in regard to social interaction, employment, social relationships, and other aspects of life decrease QOL, and create self-fulfilling prophecies in which the client lives out. For example, if an individual holds a stigmatized belief that he is inadequate in interacting with people due to his diagnosed mental disorder, he is less likely to place himself in situations that require socializing. Because of this increased isolation, QOL further decreases. In congruence with previous research, the association between stigma and QOL has been demonstrated with patients diagnosed with bi-polar disorder, and schizophrenia (Yen, Chen, Lee, et al.)
Although in the multiple regression analysis, insight was not associated with QOL among patients diagnosed with depressive disorders, insight was negatively associated with QOL using a Pearson’s correlation analysis. Thus the researchers suggest that this correlation became insignificant in the multiple regression analysis due to a variety of other variables that impact insight and QOL (Yen, Chen, Lee, et al., 2009).

**Therapeutic Solutions for this Paradox of Insight**

Various views exist regarding an individual’s ability to recovery from mental illness. Although pessimistic stigmatized view exists, current research has illustrated that a majority of people diagnosed with a mental illness do not experience unremitting dysfunction throughout the rest of their lives, and instead achieve or move towards recovery (Bellack, 2006; Harrow, Grossman, Jobe, & Herbener, 2005; Lysaker & Buck, 2008; Silverstein, Spaulding, & Mendoito, 2006 as cited in Lysaker, Glynn, Wilkniss, & Silverstein, 2010). As demonstrated, insight impairment is a commonality among patients diagnosed with mental illnesses. The therapeutic importance of increasing is well documented, however the increased risks of doing so are also well documented. Through further understanding the complexity of insight as a dynamic construct with multiple independent and interrelated dimensions, the relationship of insight and various treatment outcomes can be accomplished (Lysaker, Glynn, et al.)

**Changing Paradigms: Recovery-Oriented Approach**

This research demonstrates the need for a paradigm shift in regard to the philosophies behind therapy, as illustrated in therapy goals and interventions. As illustrated in this paper, adequate interventions and therapy programs are needed as insight is increased in therapy, to address the increased risk of clinical symptoms; anxiety; depression; hopelessness; low self-esteem; stigmatized beliefs; negative self-appraisals; poor QOL and psychosocial function; and
suicidality. The implications of previous research highlight the inadequacy and limitations of current treatment programs and interventions, thus leaving clients vulnerable to those negative risks (Lewis, 2004).

Currently, because of the encouraging research illustrating a less pessimistic view of the possibility of lifelong dysfunction among patients diagnosed with a mental disorder, the overarching goal and aim of therapy is changing (Lysaker, Glynn, et al., 2010). Thus recovery is not simply viewed as symptom control and management, but as an encompassing aim that includes how patients think of themselves and their role and experience in the world, regardless of the presence of clinical symptoms (Davidson, 2003; Resnick, Rosenheck, & Lehman, 2004; Solverstein & Bellack, 2008, as cited in Lysaker, Glynn, et al.).

To further illustrate this encompassing view of recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA; 2005, as cited in Lysaker, Glynn, et al., 2010) proposed a new definition of recovery including ten fundamental aspects. These fundamental aspects are focused on the clients’ strengths, aimed at increasing the clients’ sense of empowerment and hope for the future, as well helping the clients take responsibility over their actions. The therapeutic relationship between the clients and professional should encompass mutual respect, thereby encouraging the clients to respect themselves, as well as others. The SAMHSA model also highlights that recovery should be self-directed, holistic, and nonlinear.

Thus these clinical aims are strikingly different than simple symptom management. The presence of clinical symptoms is important, however the recovery and redefinition of the client’s meaning, significance, and identity is also important. Lysaker, Glynn, et al. (2010) illustrate that recovering from a mental illness involves a reclaiming of one’s life, by viewing one’s self as having intrinsic value that cannot be taken away by a diagnosis. Thus rejecting stigmatized
beliefs about mental illness and developing positive and hopeful beliefs regarding the self, including competencies and expectations in the future, is a critical component of recovery. Only with this growth will individuals, diagnosed with mental disorders, be equipped to re-engage in life and with others in meaningful and significant ways.

As highlighted in this paper, increasing one’s insight and awareness of having a mental disorder, properly attributing the symptoms to the disorder, acknowledging need for treatment, understanding the signs and symptoms associated with the disorder, and understanding the social consequences of the disorder (Minez et al. as cited in McLeod, et al., 2009) can leave the client feeling hopeless and depressed (Yanos, Roe, et al., 2008). The narrow and stigmatizing views of mental illness can become internalized among people diagnosed with a mental illness, thus creating a fragmented and restricted view of self, in which they see them self simply in the terms of their diagnosis. This is especially prevalent among individuals diagnosed with schizophrenia (Lysaker, Glynn, et al., 2010). Thus the aim of therapy needs to be focused on increasing a purposeful insight in the context of recovery oriented treatment. Through this context and perspective, clients can increase their level of insight and awareness, yet at the same time maintain hope.

**Narrative and Metacognition**

An essential part of this process involves assisting clients in constructing richer and deeper narratives of their lives, promoting an enriched sense of self, thus altering the clients’ self-experience in the way they interpret themselves, others, and the world (Lysaker, Glynn, et al., 2010). Two different therapeutic interventions and approaches have been hypothesized to help clients modify their self-experience, following a recovery-oriented perspective include:
altering the clients’ impoverished and/or maladaptive personal narrative, and enhancing their capacity for metacognition (Lysaker, Glynn, et al.).

Metacognition, thinking about thinking, has been demonstrated to be limited among individuals diagnosed with mental illnesses, especially individuals diagnosed with schizophrenia. Deficits in three aspects of metacognition: understanding one’s own mind, understanding of other’s minds and mastery, were associated with insight impairment, increased clinical symptoms, poorer quality of life, and neurocognitive impairments (Lysaker, Carcione, et al., 2005). Metacognition impairments have been associated with impoverished self-experience. Thus without adequate metacognition, it is very difficult to construct a narrative with the self playing an active role (Lysaker, Glynn, et al., 2010). Evidence exists supporting the notion that metacognition can be improved throughout the course of therapy, aimed at enhancing the client’s ability to think about mental states (Fonagy et al., 2002, as cited in Lysaker, Glynn, et al.).

Neurocognitive deficits can also impact one’s capabilities for metacognition. Additional research has demonstrated neurocognitive functioning impairment, primarily in the executive function, of patients diagnosed with mental illnesses (Lysaker, Buck, et al., 2007). Executive function is responsible for the flexibility of abstract thought. Thus as a consequence of impaired executive functioning, individuals have a lesser ability to view themselves in new ways, such as in the rejection of stigmatized beliefs with the perspective of themselves as an active agent within their narrative. By focusing on tasks within therapy to promote these executive function processes, these impairments could be decreased, thus improving one’s capacity to foster awareness and insight (Lysaker, Buck, et al.).

Specifically research, among individuals diagnosed with schizophrenia, illustrates that insight, self-esteem, and active and adaptive coping strategies are increased among those that
change to see themselves as active agents in their life, and tell their narratives with added coherence and richness (Lysaker & Buck, 2006; Lysaker & Hermans, in press; Lysaker, Davis, Eckert, Stratsburger, Hunter, & Buck, 2005 as cited in Lysaker, Buck, et al., 2007). Lysaker, Buck, Hammound, Taylor and Roe (2006, as cited in Lysaker, Buck, et al.) analyzed the narratives of 65 individuals with schizophrenia. Social function was rated by a clinician, and hope was rated by the individuals. The results illustrated that to the extent that the participants described themselves as active agents within their narrative, highlighting their connection to others, coping to realistic challenges, and viewing themselves as having social value, their hopefulness and social function increased accordingly.

Additionally, Lysaker, France et al. (2005) explored the relationship of elements essential in a narrative formation to neurocognition, symptoms, and insight. Each narrative was rated for plausibility (i.e., the rater’s perception of likelihood of the story’s accuracy), adequacy of detail (i.e., richness of detail mentioned in the narrative) and temporal conceptual organization (i.e., the presence of associative connections between elements within the narrative).

When insight, measured by the SUMD, was analyzed for its relationship to narrative construction the results indicated a correlation between the two, thus that individuals with limited insight received lesser scores on their narratives’ plausibility, adequacy of detail, and temporal conceptual organization. These results indicate that adequate insight is essential in constructing a rich narrative, suggesting that narrative construction within the context of therapy should be a focus. Thus as individuals explore and develop their narratives, this will promote the growth of a useable and purposeful insight, and help the clients engage meaningfully in their lives (Lysaker, France et al., 2005).
The results indicated that the degree of plausibility was correlated to the scores on the Wisconsin Card Sorting Test (WCST). These results highlight that individuals with impaired flexibility of abstract thought, as measured by the WCST, describe less plausible narratives. Additionally included in the analysis, these individuals who told less plausible narratives were also associated to be more socially isolated, as measured by the Quality of Life Scale. These results demonstrate that neurocognitive impairment is related to specific dimensions of narrative construction. This offers further understanding of the complex relationship between insight, neurocognitive impairments, and how narrative construction is influenced by insight and neurocognitive impairments differently (Lysaker, France et al., 2005).

**Essential narrative elements** Lysaker, Buck, and Roe (2007) analyzed the psychotherapy notes of 30 individuals diagnosed with schizophrenia. The psychotherapy consisted of narrative interventions. As described by McAdams (as cited in Lysaker, Buck, et al.) narratives serve the purpose of roadmaps for individuals, integrating and making sense of past and present thoughts, feelings, hopes, and experiences. These factors create a framework to interpret life events, and predict future success and failures. Narrative development consists of individuals increasing their views and beliefs of seeing themselves as active agents within their narrative (Lysaker, Wickett, Campbell, & Buck, 2003, as cited in Lysaker, Buck, et al.).

The researchers aimed to uncover essential elements in psychotherapy aimed at promoting narrative development. The psychotherapy session is divided into three sections: the opening: 1 to 5 minutes; the middle: 15 to 40 minutes; and the end: 5 to 10 minutes. In the opening the essential four elements include: (1) a signal of readiness to hear from the client (e.g., Where do you want to start?); (2) immediate placing of the client’s agenda as preeminent (e.g., the therapist positioning the client’s issue or subject as the first priority in the session); (3)
attention to the client’s immediate experience (e.g., the therapist’s attentive following of the client’s experiences in the moment, and verbalizing what it was like sitting in the office talking about it); and (4) interest in the meaning of the client’s speech from the first utterance (e.g., returning the client’s original issue throughout therapy to gain understanding) (Lysaker, Buck, et al., 2007).

The researchers also found four essential elements of the middle section: (1) reflection about the clients’ presence or absence as the protagonist in the stories they tell (e.g., inviting the clients to explore their feelings and actions); (2) reflection about how the client experienced the therapist, as an audience for the story (e.g., the therapist helping the client to reposition the therapist as one with whom he could continue sharing his narrative; (3) responses to the clients’ difficulties thinking of themselves accomplished through recognizing the clients’ right to have and create their own story and offering to help, filter, or change the client’s perspective (e.g., the therapist helping the client explore how the client constructed his story, or failed to construct a story); and (4) reflection of possible issues not mentioned (e.g., highlighting any missing information, such as things that are going well for the client) (Lysaker, Buck, et al., 2007).

Finally, the third section of the session consisted of three essential parts: (1) mention of the session coming to an end (e.g., the therapist giving a signal indicating this), (2) invitation for the clients to frame their experience of the session (e.g., the therapist inviting the clients to reflect on the session, but also on their narrative exploration); and (3) mention of scheduling of next session (e.g., recognizing that future sessions need to be mutually agreed upon) (Lysaker, Buck, et al., 2007).

This article provides further understanding of the critical elements involved in deepening and enriching the narratives of clients diagnosed with schizophrenia. The authors highlight the
importance of helping clients, diagnosed with a variety of mental disorders, not only schizophrenia, create significance in their lives by making sense of their world, including what is wrong and not wrong in their lives, what hopes, dreams, and expectations they grieve and hope for, and what they can do to live that out (Lysaker, Buck, et al., 2007). Through altering the narratives of clients, clinicians can better equip participants for coping and adjusting to the consequences of insight into their mental disorder, thus improving their recovery outcomes.

Self-Complexity

In a similar accord, Martens (2009) proposed the importance of the clients’ self-complexity to protect against the negative risks associated with increased insight. Self-complexity refers to the number and distinctions between self-aspects (i.e., sub-selves). These self-aspects include past behaviors and events, generalizations of one’s behavior, and self-perceptions, beliefs and evaluations of one’s traits, characteristics, roles, physical features, capabilities, relations to others, and category membership. These related self-concepts help answer questions related to who the individual thinks he or she is, and how the individual feels about him or herself, resulting in appraisals of worth, definition, and self-esteem (Linville, 1987, as cited in Martens, 2009).

Previous research has shown that a higher number of self-aspects and greater distinction among the self-aspects guard against depression through positive automatic thoughts as opposed to negative automatic thoughts (Yoshida & Nakamura, 2007 as cited in Martens, 2009). Martens highlights that essential to recovery and buffering against the negative effects of insight is an individual’s ability to develop an authentic self characterized in autonomy, character strength, independent opinions and attitudes, and self-realization. Additionally, an individual should develop a capacity for internal dialogue in order to explore and learn about his or her self
and what it means to be an individual (Martens 2005; 2007, as cited in Martens). In an analysis, two components of the self-complexity theory, one’s ability for awareness and reflection of one’s own thoughts and emotions, and those of other peoples (i.e., mindreading), and were associated to well-being (Dimaggio et al., 2008, as cited in Martens).

Martens (2009) highlighted that some individuals diagnosed with schizophrenia may have insufficient self-complexity, illustrated in fewer sub-selves, and lesser integration of those sub-selves. Thus when insight is increased, these individuals do not have an adequate self-concept unity to cope with the consequences of that insight. Thus not all individuals diagnosed with schizophrenia experience the negative effects associated with increased insight; as the theory proposes, only the individuals with the inadequate self-complexity experience them (Martens).

Because higher self-complexity allows for the flexibility to adjust, cope and change in regard to inaccurate or incomplete self-schemas, individuals with higher self-complexity have greater ability to change their perspective and thinking to fit with the newly increased insight (Martens, 2009). This flexibility is evident in an individual’s thoughts, appraisals, outlook and perspective, and self-roles and definitions. Thus higher self-complexity provides the mechanisms for self-regulation in regard to psychosocial, social-emotional, and cognitive aspects through a process of gaining information from the outside world, and processing it among the mechanisms of self-complexity, such as self-knowledge and self-concepts. Thus individuals are prepared cope adequately against self-errors in thinking and attributing (e.g., poor insight); stigmatization of mental disorders; and the impact of negative experiences associated with one’s mental disorder (Martens).
Martens (2009) proposes that increasing self-complexity among individuals diagnosed with mental disorders should be a therapeutic goal to guard against the risks of increasing insight. This aim can be achieved through the process of individuals developing a narrative of their lives. This process would increase self-investigation and self-awareness, as well as encourage the individuals to explore the external world, thereby increasing dialogue and interchange between the internal and external worlds. This process would help individuals recovering from schizophrenia to make meaning and congruency out of their seemingly disintegrated experiences. Lysaker and Lysaker (2010) also highlight the importance of narrative construction among individuals diagnosed with schizophrenia. Because of the self-perceptions of a loss of identity frequently mentioned among these individuals, regaining a sense of security and meaning is an important therapeutic goal.

**Application of Recovery-Oriented Approach**

This changing therapeutic perspective towards a recovery-oriented approach extends beyond individuals diagnosed with schizophrenia. A 9-year follow-up study investigating the effectiveness of psychotherapy with individuals diagnosed with dysthymia and panic disorder highlighted essential elements germane to the individuals’ recovery process (Svanborg, Baarnhielm, Wistedt, & Lutzen, 2008). The authors suggested a general model of recovery should consist of the clients’ thorough understanding of themselves and their illness, resulting in a sense of empowerment, hope, and confidence in their capabilities to handle challenges in their future. The clients should also shift from avoidant to approach coping, as well as enhance their flexibility of thinking (Svanborg, et al.). Thus the applicability of the highlighted paradigm shift to a recovery-oriented therapy aimed at fostering a usable insight while maintaining hope to mental disorders beyond schizophrenia is illustrated.
Adlerian Theory

Adlerian theory is also a recovery-oriented approach that offers a solution for this observed paradox of insight by helping clients develop a usable and purposeful insight, while maintaining hope. The elements of Adlerian therapy are very compatible with the previously highlighted research, illustrating the importance of narrative construction, metacognition, and self-complexity for the development of a recovery-oriented insight.

The philosophy behind Adlerian theory consists of a theory of use, rather than a theory of possession. From a medical model perspective, a theory of possession, patients are diagnosed with a disorder. The patient has now come to possess that specific disorder (Griffith & Powers, 2007). This philosophy of thought is illustrated in the common phrases, “Bi-polar woman,” “Cancer patient,” “Obsessive-compulsive child,” and “Schizophrenic patient.” As illustrated these diagnoses have now come to define the individual. These labels and definitions associated with clients’ worth and identity can dramatically change the way in which they view themselves, and their future. Stigmatized views on mental illnesses further perpetuate the negative appraisals and evaluations. Thus, it can be seen why clients limit their insight their mental disorder, thereby protecting against the personal implications of these limitations and deficits. However in Adlerian therapy, by defining the clients outside of, and beyond their diagnosis, the clients no longer need to protect themselves from these negative appraisals and evaluations associated with “having a mental disorder” (Carlson, Watts, & Maniaci, 2006; Griffith & Powers).

Alfred Adler referred to this concept as safeguarding. By safeguarding, clients act in ways that protect their self esteem, and guard against feelings of inferiority. From this teleological perspective, neurotic symptoms serve the purpose of this safeguarding role.
Through encouragement, re-education, and reorientation, Adlerian counselors can help clients understand their safeguarding beliefs and behaviors. Adler identified this task to be the most important task of psychotherapy (Dinkmeyer & Sperry, 2000). Clients are not viewed as being sick, but simply as being discouraged. Psychopathology occurs when individuals become rigid in thinking.

Encouragement is an essential element to Adlerian therapy, which is very pertinent to therapeutic solutions for the paradox of insight. Encouragement (as defined by Carlson et al., as cited in Corey, 2009), is characterized through various techniques aimed at showing faith in people, valuing who they are, and expecting them to take responsibility over their lives. By providing this encouragement, Adlerian counselors illustrate: faith in the individual, and the individual’s ability to change within the counseling process; hope for the individual in the midst of challenging circumstances and discouragement; and love for the individual expressed in a caring, and empathic way (Mosak, 2000, as cited in Carlson, Watts, & Maniaci, 2006).

Through encouragement, clients gain the ability and motivation to gain insight into their lives and mental disorder. Thus the protective mechanisms behind insight impairment are decreased because of the client’s growing belief in themselves and their ability to change.

Exploration of the client’s Lifestyle is a critical element of Adlerian therapy. In this process, the how and why the individual makes meaning and value out of their life will be understood. An individual’s Lifestyle is formed as a young child, usually before the age of 5 or 6. As children grow up, they continue to interpret, and assess the world, and formulate behaviors based on these beliefs. Adlerian theory is a psychology of movement; people think, and behave in ways that move them from a state of feelings of inferiority towards a goal that is perceived to
be beneficial. This fictional goal guides our choices, yet clients are usually unaware of these rules and beliefs that they live by (Corey, 2009).

An individual’s Lifestyle functions in a variety of roles: a guide, a limiter, and predictor (Carlson, et al., 2006). First, Lifestyle serves as a guide or direction setter to organize their movement through life experiences. Lifestyle also limits the individual’s range of behaviors, beliefs, and responses based on previously learned behaviors. Thus the individual’s behavior will reflect his or her learned style of being in the world. Finally, Lifestyle serves as a predictor, providing security and regulation to the individual’s life. Lifestyle is formed and functions through the processes of biased apperceptions (i.e., perceiving only stimuli of which the individual attaches meaning to), self-reinforcement (i.e., seeking out experiences to reinforce expectations and beliefs), and arrangement (i.e., prompting others to confirm or verify expectations) (Carlson, et al., 2006).

Thus, in accord with one’s Lifestyle, individuals develop a private logic of how the world works. Without an adequate feedback system to the outside world and common sense, an individual’s private logic may go unchecked and become rigid, resulting in maladjustment (Carlson, et al., 2006). Because of feelings of inferiority, individuals may guard against insight into the unrealistic nature behind their private logic. By assisting clients with insight into these unrealistic beliefs, while maintaining hope and encouragement for the client’s ability to change, clients can begin to engage in a self-regulatory system, amending their troublesome private logic.

This concept is very similar to the self-complexity model proposed by Martens (2009), contending that individuals diagnosed with mental disorders lack the complexity and distinction among various sub-selves. Because of the lack of development of self-concepts, individuals are limited in their ability to regulate and amend any self-concepts and beliefs that are not consistent
with the outside world. Thus, when these individuals gain insight into their life and mental disorder, they lack the ability to recreate and redefine meaning and security within the context of their changed perspective, precipitated by the increased insight. Through Adlerian exploration of Lifestyle, and private logic, therapists can help individuals identify and alter their beliefs about themselves, others, and life. Thus it is clear, as Adler stated, “A man is not determined by his environment, but by his estimation of it” (as cited in Rozsnafszky, 1974, p. 68). Similar to narrative construction advocating for individuals to develop narratives in which the self places an active protagonist role, Adlerian theory holds similar views and goals. They view clients, and help clients view themselves as active creators in their lives driven by goals, and responsible for their actions, thoughts, and feelings, as opposed to helpless victims (Corey, 2009). The basic goals of Adlerian therapy consist of helping the clients participate and engage more fully in the social world, accomplished by helping clients identify and change their mistaken beliefs about themselves, others, and the world (Corey).

This Adlerian therapeutic relationship and process are compatible with the essential narrative elements research by Lysaker, Buck, et al., (2007). This research highlighted the importance of the therapist’s recognition and exploration of concerns of the clients in the beginning of the session and the therapist’s exploration of the clients’ strengths and weaknesses, as well as their experiences, perceptions, and meanings in the middle of the session. Additionally, in the middle of the session, the research highlighted the importance of the therapist helping the clients understand their own perceptions, and offering any feedback, guidance, or changes. This aspect is compatible to helping the clients understand their Lifestyle, and identify and alter any fictions and beliefs that are causing them problems (Oberst & Stewart, 2003). Finally, at the end of the session, the research emphasized the importance of discussing
the possibility of another session, if both the counselor and the client agree on it. This is compatible with the context of Adlerian therapy, illustrated with mutually reached goals, and participation in therapy, illustrating the client’s active role in the therapeutic relationship (Corey, 2009).

Meaningful engagement and involvement in one’s life can also be explored within Adlerian therapy through the concepts of Social Interest and the Life Tasks. Social Interest refers to an interconnectedness of an empathic bond of a community feeling, resulting in an action of Social Interest (Ansbacher, 1992; Mosak & Maniaci, 1999; Stein & Edwards, 1998, as cited in Carlson et al., 2006). From an Adlerian perspective, everyone strives for belonging. Adler believed that the strongest motivational factor for individuals is to belong to their social world. This is manifested in Social Interest (Griffith & Powers, 2007). One goal of Adlerian therapy is to increase the client’s development and expression of Social Interest. This Social Interest is applied to the three life tasks: social, work, and love. By assessing these tasks, and problems associated to these tasks, Adlerian therapists can help the client meet the demands of these tasks (Griffith & Powers, 2007). This can be accomplished through developing insight into these tasks, as well as associated mistaken beliefs and feelings of inferiority, while encouraging the client to think and behave in different ways. Similar to narrative construction, and metacognition, encouraging the clients to evaluate and alter their belief systems, self-evaluations and self-appraisals, meaning and engaging psychosocial functioning can be established in their lives, despite a mental disorder diagnosis.

Thus as highlighted, because of the emphasis of Adlerian therapy assisting clients in defining themselves and changing mistaken beliefs of themselves, others, and the world to meaningfully engage in the world, the research on narrative, metacognition, and self-complexity
can be interpreted as support for the Adlerian perspective. Corey (2009) highlights the strength of Adlerian therapy in its integrative and eclectic approach, using techniques and interventions from a variety of cognitive, behavioral, and experiential domains. This relationship also goes the other way, by which the roots of contemporary theories of: reality, Gestalt, learning, rationale emotive behavior, cognitive, person-centered, existential, and postmodern have their foundations in Adlerian theory (Corey). Thus, all the research previously highlighted can be viewed as further evidence for the applicability of Adlerian interventions in developing a usable, and purposeful, recovery-oriented insight.

**Conclusion**

In conclusion, this paper explored the paradox of insight, illustrating the detrimental risks associated with increasing insight in therapy, as well as the risks of associated with insight impairment. The exploration of additional psychosocial and neurocognitive factors influencing this relationship provided further understanding of the complex and dynamic construct of insight. The current limitations and inadequacies of assessing the associated risks of increased insight were highlighted, proposing a therapeutic paradigm shift to recovery-oriented treatment models, through which a usable and purposeful insight is developed, helping clients create meaning and preserve hope. The recovery-oriented approaches of Adlerian theory, as well as narrative constructive, metacognition, and self-complexity were highlighted as effective therapeutic approaches and interventions.
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