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Commentary

Insight in psychosis: An independent predictor of outcome or an explanatory model of illness?

K.S. Jacob *

Christian Medical College, Vellore 632002, India

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ABSTRACT

While the traditional view within psychiatry is that insight is independent of psychopathology and predicts the course and outcome of psychosis, recent data from India argues that insight is secondary to interaction between progression of illness on one hand and local culture and social environment on the other. The findings suggest that "insight" is an explanatory model (EM) and may reflect attempts at coping with the devastating effects of mental disorders.

Most societies are pluralistic and offer multiple, divergent and contradictory explanations for illnesses. These belief systems interact with the trajectory of the person's illness to produce a unique personal understanding, often based on a set of complex and contradictory EMs. Like all EMs, insight provides meaning to explain and overcome challenges including disabling symptoms, persistent deficits, impaired social relations and difficult livelihood issues. The persistence of distress, impairment, disability and handicap, despite regular and optimal treatment, call for explanations, which go beyond the simplistic concept of disease. People tend to choose EMs, which are non-stigmatizing and which seem to help explain and rationalize their individual concerns. The frequent presence of multiple and often contradictory EMs, held simultaneously, suggest that they are pragmatic responses at coping.

The results advocate a non-judgmental approach and broad based assessment of EMs of illness and their comparison with culturally appropriate beliefs, attributions and actions. The biomedical model of illness should be presented without dismissing patient beliefs or belittling local cultural explanations for illness. Clinical practice demands a negotiation of shared model of care and treatment plan between patient and physician perspectives. The diversity of patients, problems, beliefs and cultures mandates the need to educate, match, negotiate and integrate psychiatric and psychological frameworks and interventions. It calls for multifaceted and nuanced understanding of "insight" and explanatory models of illness.

1. Introduction

Insight is defined as "a patient's capacity to understand the nature, significance and severity of his or her illness" (Sims, 2009). It can range from an awareness of one's context to a deeper intellectual understanding and emotional appreciation of issues. Its understanding has major clinical implications for phenomenology, clinical management, help seeking and treatment compliance.

2. Traditional view

Research related to insight in psychosis and in schizophrenia has changed substantially over the past few decades. Older trans-cultural studies employing all-or-none perspectives in the elicitation of insight (WHO, 1973; Wilson et al., 1986) have given way to more sophisticated multi-dimensional models (Surguladze and David, 1999; Amador and David, 2004; David, 2004, 1990). Insight is now defined as a multidimensional construct encompassing (i) awareness of illness, (ii) relabeling of symptoms, and (iii) recognizing need for biomedical treatment (David, 1990).

Investigations have documented the inverse relationship between psychopathology and insight scores (Mintz et al., 2003; David, 2004; Saravanan et al., 2007a, 2010; Drake et al., 2007; Mohamed et al., 2009). Studies have also recorded a relationship between a lack of insight with impaired cognitive functions (Aleman et al., 2006) and with changes in functional magnetic resonance imaging (van der Meer et al., 2013; Spalletta et al., 2014).

Many investigations, which have attempted to examine the association between insight and course of illness, have reported

* Tel.: +91 416 2284513.
E-mail address: ksjacob@cmcvellore.ac.in

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that good insight is associated with better clinical outcomes (David, 2004). Poor insight is a predictor of non-adherence to treatment and it predicts higher relapse rates, aggression, involuntary hospitalizations, poor social outcome and course of illness (David, 1990).

Lack of "insight" includes unawareness of the symptoms of schizophrenia and may be present throughout the course of illness (APA, 2013). It has been suggested that insight is shaped by constraints of biology (i.e. cognitive impairment and *anosognosia*) and by psychology (i.e. motivation and denial) (Amador and David, 2004; Saravanan et al., 2004). Nevertheless, insight is also influenced by social constructions of illness (e.g. culture specific explanatory models) (Amador and David, 2004; Saravanan et al., 2004).

3. Recent evidence

Recent evidence is briefly highlighted and includes (i) insight and explanatory model of illness, (ii) single and multiple explanatory models, (iii) insight and psychopathology, (iv) assessment of insight, (v) cross-sectional correlations, (vi) longitudinal associations, (vii) changes over time, (viii) predictors of outcome, and (ix) insight and biology.

3.1. Insight and explanatory model of illness

"Explanatory models are the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (Kleinman, 1980). *Emic* models elicit patient perspectives by the way he/she conceptualizes the sickness episode including beliefs and behaviors concerning etiology, course, timing of symptoms, meaning of sickness, diagnosis, methods of treatment, roles and expectation of sick individuals. *Etic* models, on the other hand, are perspectives usually based outside the subject's culture; include physician perspectives about the patient's illness. The underlying dichotomy distinguishing local insider and professional outsider perspectives is applied to the relationship between explanatory models and clinical diagnosis and to the relationship between illness and disease (Kleinman, 1980, 2013). EMs influence many aspects of human behavior like help seeking, treatment compliance, patient satisfaction and coping. EMs play an important role in patient–physician interaction and health related behavior.

From an EM perspective, insight in psychosis is the degree of congruence between patient and physician viewpoints. Good insight is inferred when the patient endorses the physician's biomedical perspectives by acknowledging awareness of illness, relabeling symptoms and accepting the need for medical treatment (i.e. congruence with biomedical model). On the other hand, discordance between patient and physician points of view suggests poor insight.

3.2. Single and multiple explanatory models

Insight research often assumes that patients hold solitary beliefs about their illness. Many reports, which have systematically elicited EMs, have documented the presence of multiple and contradictory beliefs about illness across cultures (Kapoor, 1975; Gater et al., 1991; Lloyd et al., 1998; Joel et al., 2003; McCabe and Priebe, 2004; Saravanan et al., 2007a,b, 2010; Johnson et al., 2012, 2013, 2014). EMs are usually a conglomeration of emic and etic approaches involving ethnocultural, personal and idiosyncratic beliefs and components from both within and outside culture. People with mental illness, especially those with chronic and debilitating conditions, seek help from diverse sources. Those who do not benefit with treatments from modern medicine often seek help from traditional and alternative medicine and from faith healers and vice versa (Jacob, 1999).

Multiple and contradictory EMs of illness, considered the norm in low and middle-income countries, have also been demonstrated in Western populations (Lloyd et al., 1998; McCabe and Priebe, 2004). Pluralistic societies employ multiple approaches to health and illness (Jacob, 1999). The fact that people with non-medical beliefs regularly take psychotropic medication (Saravanan et al., 2007a,b, 2010; Johnson et al., 2012, 2013, 2014) argues for the complexity of the response to chronic and disabling illness. Research has documented a complex list of reasons and circumstances, which facilitate medication compliance and which are not necessarily voluntary or rational (Tranulis et al., 2011).

3.3. Insight and psychopathology

The reciprocal relationship between insight and psychopathology (Mintz et al., 2003; David, 2004; Saravanan et al., 2007a, 2010; Drake et al., 2007; Mohamed et al., 2009) suggests its association with delusional thinking and beliefs. However, severe delusional illnesses, by their definition, preclude alternative explanations in those with severe disease, especially at the height of their illness. Thus, people with severe illness, will by definition lack insight as they will believe in the validity of their psychotic experience and will not be able subscribe to a biomedical understanding for their condition. Therefore, people with milder forms of psychosis, who acknowledge disease within themselves rather than alternative explanations for their psychotic experiences, will be considered to have insight. Consequently, people with good insight will be those with milder disease, who are able to entertain and consider alternative biomedical explanations for their illness, which suggest disease and will, therefore, have better clinical outcomes compared to those with more severe psychotic states who firmly believe in their delusional convictions.

3.4. Assessment of insight

The instruments employed to assess insight focus only on the biomedical model of illness, with good insight corresponding with disease attributions and the acceptance of medical treatments (Kemp and David, 1997; Sanz et al., 1998). These instruments do not consider locally and culturally relevant attributions and help seeking as a measure of insight. Consequently, individuals who offer biomedical explanations for their illness score higher on measures of insight, while those who subscribe to non-medical beliefs are considered lacking awareness. Hence, such correlations between insight and biomedical EMs are natural considering the fact the instruments to evaluate insight, only accept disease explanations, attributions and actions, and concentrate on the recognition of mental illness and seeking medical and psychiatric treatment. Therefore, people with milder episodes of psychosis, who acknowledge disease within themselves, will be reported to have good insight while those with severe illness, who solely believe in their delusional ideas, will be considered to lack such understanding.

3.5. Cross-sectional associations

Investigations have reported an inverse relationship between psychopathology and insight scores (Mintz et al., 2003; David, 2004; Saravanan et al., 2007a, 2010; Drake et al., 2007; Mohamed et al., 2009). Studies, which examined non-medical EMs of illness, have demonstrated their negative relationship with insight scores (Saravanan et al., 2007a, 2010). However, cross-sectional associations are often mistakenly assumed to have a directional relationship, with poor insight and non-biomedical EMs predicting