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Review

Much ado about everything: A literature review of insight in first episode psychosis and schizophrenia

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1. Introduction

Insight is a complex mental state which is influenced by the interaction of various factors, particularly at the psychologic, biological and sociocultural levels. Even if it has sometimes been considered as impossible to capture, the concept of insight is nevertheless valid, since it is correlated with a certain number of the challenges faced both by patients affected by mental illness and by the clinicians who attempt to propose treatment [1,2]. In addition, the observation of a correlation between certain neurological substrates, such as for example perfusion of the precuneus [2], and degree of "insight", can also be regarded as elements supporting the validity of this concept. Today, "insight" is considered as a multidimensional notion for which there is no unitary definition [3]. In the field of psychosis and more particularly schizophrenia, the definition that is most often found in the literature is based on the presence of both the acknowledgment by the patient of the presence of an illness and the necessity of treatment [4,5]. All the authors underline the fact that insight remains a key dimension to explore in the clinical assessment process. Indeed the absence of insight increases for example the risk of non-adherence to medication in subjects who experienced a first episode psychosis (FEP) [6] and represents a major risk factor of unfavorable functional outcome in schizophrenia [7]. Conversely, the presence of insight decreases the risk to act on delusional ideas, facilitates the establishment of a therapeutic relationship and improves the relationship with the family [1]. It is thus reasonable to think that a better understanding of the drivers of insight would allow its early promotion from the first psychotic episode, which in turn may optimize the chances of recovery in this population. This task is however made difficult by the complexity of the concept, the various explanatory models proposed so far and the numerous links it weaves with a certain number of independent factors such as the duration of untreated psychosis (DUP), the affect, the patients' sociodemographic situation and their possible addictive behaviors [8]. In this literature review, we propose to take stock of the state of knowledge around the question of insight, its conceptualization, the suggested explanatory models and the therapeutic approaches likely to be able to improve it. We conducted a broad literature search on English and French databases up to 2015 and selected relevant articles using insight, awareness of illness, psychosis, first episode psychosis, schizophrenia as key words.

2. Conceptualization

The conceptualization of insight has progressed tremendously over the last thirty years. Indeed, the categorical approach of insight has long prevailed and implied a binary conceptualization where insight was either present or absent. Thus it was considered that the insight of a patient was preserved as long as he adhered to the explanatory model of the assessor. Recent work made it possible to consider a multidimensional and evolutive approach of

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insight [9–12]. Thus a continuum would exist between the presence and the absence of insight on the basis of independent dimensions. Lewis claimed that the insight is initially concerned with the recognition of a change and then with the judgment that one allocates to it [13]. More recently, Greenfeld [14] proposed to define five dimensions to insight: (a) the recognition of the presence of symptoms, (b) the recognition of the disease, (c) an etiologic reflection, (d) the perception of a vulnerability to relapse and (e) the importance of treatment. David [11] proposes three partially superposable dimensions: (a) the recognition by the patient that he suffers from a mental disorder, (b) treatment adherence and (c) the capacity to identify the pathological nature of the acute features of the disease. Similarly, Amador and Strauss [15] insist both on the processes of recognition of symptoms and of the disease, and on the concept of attribution, i.e. the attempt to explain the symptoms in relation to an etiology. It is however useful to note that the various attempts at conceptualization of insight did not integrate in their definition the importance of the sociocultural context of the patients in the evaluation of insight [16] even if it is recognized. Moreover, if insight has a dynamic and fluctuating course in the same individual, it does not seem to have the same psychopathological value from one mental disorder to another. Indeed, some authors consider that the lack of insight represents a feature of schizophrenia [17] whereas it would be related to the intensity of symptomatology in bipolar disorder [18].

3. Assessment tools

The various assessment tools used were created in order to help the clinician in the evaluation of insight but also for the purpose of research. The choice of an instrument is determined on the basis of: (a) the identification of the assessor (self vs expert-rated questionnaires), (b) the conceptual approach (categorical/dimensional), (c) the quantitative or qualitative nature of the instrument, (d) the explanatory model on which the instrument hinges (clinical/cognitive insight) and (e) the concept of temporality (recognition of a past or current mental disorder).

The main quantitative scales used for the evaluation of insight in psychosis are presented in Table 1. Qualitative approaches can also be used in which the assessor transcribes the remarks of the patient while trying to identify sets of themes and to extract a relevant significance from them [14].

The SUMD (Scale for the assessment of Unawareness of Mental Disorder) is currently the most complete and utilized scale in literature. It is mainly used in clinical trials and epidemiological studies. A shorter version has been validated for clinical practice [29]. It evaluates in particular the conscience of having a mental disorder, at the time of evaluation or in the past, the signs and symptoms of the disease, the benefit of treatment, as well as the psychosocial consequences, secondary to the mental disorder. It showed a construct and criterion validity as well as a good reliability [10]. If it has the advantage to evaluate various relevant dimensions of insight, it insists nevertheless on the need for taking into account certain important principles at the time of assessment: (1) insight is a complex and multidimensional concept, (2) cultural factors must always be taken into account, (3) dimensions have to be measured on the basis of a continuum, (4) the degree of insight can vary according to the various features of the disorder, (5) the preliminary level of information related to the disorder and its manifestations must be taken into account at the time of the evaluation.

Table 1
Quantitative assessment tools for the evaluation of insight in psychosis.

	Categorical	Dimensional
Clinical insight		
Self-rated	PANSS, item G12 [22]	SRIS 2 [19]
		SAIQ [20]
		IS [12]
		VAGUS-SR [21]
Expert-rated		SUMD [23]
		SAI [11] and SAI-E [24]
		ITAQ [25]
		Q8 [26]
		VAGUS-CR [21]
Cognitive insight		
Self-rated	BCIS [27]	
Expert-rated	MIC-CR [28]	

4. Explanatory models

4.1. Psychological models

4.1.1. Denial

According to a first conceptual level, the lack of insight can be linked to a defensive strategy forged by the patient in order to protect himself from stigmatization related to the negative stereotypes of the illness which suggest inevitable chronicity. Denial thus makes it possible for the patient to avoid a psychological collapse by refusing to endorse the role of patient [30,31]. This psychological reaction vis-a-vis the "threat of self-stigma" [32] is particularly seen among teenagers and young adults who experience FEP and represents a psychological answer which is appropriate to their age. Denial of psychosis in its early phase can even constitute a resource for the subject in his will to recover [1,14].

McGlashan et al. [33] proposed to define the process of acceptance of psychosis and its symptoms through a continuum where integration (merging of the psychotic experiment to the subject's system of values) and sealing over (dissociation from the system of values) would be the two extremes.

4.1.2. Cognitive maps

Beck et al. [27] proposed to differentiate clinical insight from cognitive insight. Whereas clinical insight reflects the conscience of the disease and causal symptomatology, cognitive insight relates to the subject's capacity to question his own beliefs after evaluation and reinterpretation of certain erroneous beliefs. The scale developed by this team presents two subscales evaluating the reflection on oneself (*self-reflection*), and the level of certainty based on one's own beliefs (*self-certainty*). A low level of insight would thus be characterized by an elevated level of certainty and a lack of self-reflection [34].

According to certain cognitive theories, the deficit of insight in psychosis would be related to an excessive use of normal and adaptive mechanisms of cognitive distortion allowing the protection of self-esteem [9,15]. The theory of cognitive dissonance brings an explanation on the strategies a subject tries to apply in order to cope with the upheaval of a psychotic episode and to solve its existential dilemmas. According to this theory, when the circumstances push a person to act contrary to his system of beliefs, he will experience a feeling of psychological discomfort called dissonance. Generally, the occurrence of a dissonance leads to a problematic behavior; the subject will change his attitude so that it would be in conformity with the initial problematic behavior. The stronger the dissonance, the more important the endeavor of reduction of the dissonance [35]. Thus, for a patient experiencing psychosis, denial will tend to be more active in order to restore balance and to reinforce the belief of not being sick. With subsequent episodes, behaviors related to the psychotic symptoms will create new dissonances likely to modify the initial beliefs.

The concept of dispositional shift, part of the attribution theory, reflects the concept that with time an individual more easily