



Insight in schizophrenia, its fundamental connection to fragmentation and potential as a treatment target: A commentary on Phahladira et al.

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Phahladira et al. (2018) present a study of clinician and patient assessments of insight over 24-months among 105 individuals diagnosed with a first episode schizophrenia spectrum disorder. The study offers the important finding that over time this group became more accepting of the need for somatic treatments but did not show any changes in their sense of whether or not they suffered from a mental illness. The authors conclude that poor insight may be a trait feature of early psychosis and an aspect that is generally not responsive to antipsychotic medication. They note the persistence of poor insight is concerning, given the links of poor insight with a reduced likelihood of being able to accept potential treatment leading to poorer clinical and psychosocial outcomes.

Taken as a whole, these results are not surprising. They match those of older studies (Carpenter et al., 1976) and foundational clinical observations (Bleuler, 1950). Importantly, the results raise the subject of how to responsibly help persons diagnosed with schizophrenia make sense of whether they suffer from a mental illness and, if so, how they would like to manage it. Before this issue can be approached however, there is a more substantial question to be addressed first; namely, what are the processes which culminate in and sustain poor insight.

What sets of phenomena intersect such that persons fail to form an adaptive sense of the events and experiences which others characterize as mental illness? Indeed, how could an intervention that might treat poor insight be formulated without a firm idea of what poor insight reflects?

There are several long-standing models of poor insight which have failed to adequately characterize and explain this phenomenon. In one folk version, often implicit in the psychoeducation literature, poor insight is cast as an educational deficit, as the failure by a patient to collect or accept a series of facts that are apparent to others. In a better described model, endorsed in the DSM (American Psychiatric Association, 2013), poor insight is similar to anosognosia or instances in which patients with neurological conditions fail to notice the emergence of a specific problem, like a change in speech or gait. These views of poor insight, however, fail to recognize that schizophrenia involves a broad series of morbid changes in the course of a person's life, and so poor insight itself reflects an inability to see or make sense of those changes (Lysaker et al., 2018). To be aware one has developed schizophrenia, persons must integrate a host of information including historical events, changes in thoughts and emotions, and the perception of others; combined, these factors allow for the understanding of the complex and potentially traumatic changes in a unique life.

One model which has the potential to account for insight and direct the development of treatment is the integrative model of insight (Vojs et al., 2016). This model proposes that awareness of a mental disorder requires the integration of experience and as such, disturbances in any number of different processes could result in a fragmented sense of one's self and poor insight. For example, anomalous self-experiences may result in thoughts and emotions which are difficult to understand or place in a context of an unfolding mental illness. Deficits in attention and memory may make it difficult to distinguish and recall the key events of an experience of mental illness, while deficits in executive function may make it difficult to shift one's ideas about the causes and interrelationships of different psychiatric challenges. Stigma may make it poisonous to one's identity to accept one has psychiatric challenges. Deficits in social cognition may complicate a person's ability to benefit from the perspective of others. Finally, superordinate deficits in metacognition may compromise general abilities to integrate information into a sense of oneself and others, within the flow of life, resulting in a diminished capacity to see how events and experiences could be understood to reflect mental health challenges. Evidence of

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this includes a recent latent class analysis which found significant levels of metacognitive deficits occurred among groups with poor insight but differing symptom profiles (Lysaker et al., 2019).

The integrative model of insight thus appears capable of understanding how awareness of a broad set of phenomena could be compromised. It is also consistent with historical models of schizophrenia as a disorder of fragmentation (Bleuler, 1950) and emerging models of recovery (Leonhardt et al., 2017) which suggest wellness is supported by a coherent account of psychiatric and related life challenges, spurring adaptive responses rather than focusing narrowly upon the acceptance of a particular medical model of illness. Mostly importantly, returning to the findings of Phahladira et al. (2018) this points to potential ways to intervene. Above all else, the integrated model of insight points to the need to create interventions which go beyond passive reliance upon medication or simply teaching persons about their illness. This model highlights the need to help persons diagnosed with these conditions make sense themselves of these challenges in a way that favors self-management and recovery. It requires thinking with patients while remaining sensitive to the complexities and difficulties which are barrier to the formation of an integrated sense of personal experience for these persons.

Optimistically, this view has led to the development of new interventions which have shown promise in preliminary studies. Pijnenborg et al. (2018), using a related multidimensional model of insight have shown that REFLEX, a group intervention with social cognitive, anti-stigma, and neurocognitive components can lead to improved clinical insight. Vohs et al. (2017) have reported that a modified form of Metacognitive Reflection and Insight Therapy (MERIT) resulted in clinically and statistically significant improvements in adults with first episode psychosis.

In summary, Phahladira et al. (2018) call our attention to the need to attend to potentially persistent issues with poor insight in early psychosis. In this commentary we have suggested that new models of insight, which frame it as a multidetermined, personal understanding of psychiatric challenges, may provide direction for how to meaningfully address poor insight, noting how this new model has led to two new forms of intervention.

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