Editorial
Άρθρο σύνταξης

Insight across mental disorders: A multifaceted metacognitive phenomenon

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There is now general agreement that lack of insight is not merely a fundamental aspect of delusions and hallucinations, or just a symptom of psychotic disorders but rather a multi-dimensional construct. Several different components of insight have been proposed and empirically examined during the last three decades, such as the ability to recognize that one has a mental illness, the capacity to relabel unusual mental events as pathological, the specific attribution of one's symptoms to having a mental illness, awareness of illness' consequences, and compliance with treatment.[1] Insight impairment is an important prognostic factor in schizophrenia, impacting negatively on medication adherence, treatment outcome, and social functioning.[2]

Although largely investigated in schizophrenia and other psychoses, insight impairments are observed in many, if not all, mental disorders. Varying levels of awareness of mental illness and/or of specific symptoms are expected in patients with bipolar disorders, Alzheimer disease and other neurocognitive disorders, obsessive-compulsive (OCD) and related disorders.[1,3] While in DSM-5 an "insight" specifier was incorporated for OCD, body dysmorphic and hoarding disorder, patients' insight has been found ranging from good to absent in other disorders, such as depressive disorders,[4] eating disorders,[5] and even specific[6] and social[7] phobias. Moreover, impaired insight is a common reason that many people with clinical depression or anxiety disorders never seek appropriate treatment and most of the people with addictions and personality disorders fail to recognize and address their problems even when the consequences are devastating: personal suffering, broken relationships, and physical health problems. Depending on the disorder and reflecting different conceptual approaches, many different terms are used to describe lack of insight, such as poor self-awareness, denial, anosognosia (mainly in neurological deficits, e.g. hemiplegia), ego-syntonic symptoms, or even self-deception.

At any rate, as an aspect of self-knowledge, insight has psychological (defense mechanisms, coping strategies), social and cultural facets. On the other hand, the attitudes and behaviours towards one's illness are products of inference processes and therefore can be influenced by cognitive dysfunctions. Previous research in schizophrenia showed correlations between neurocognitive functions and insight measures but the strength of this association is rather weak.[8] Social cognition may be a crucial cognitive determinant of impaired insight in schizophrenia. The correct attitude toward morbid change in oneself relies on the capacity to reflect upon self from the perspective of the other (i.e., "to see ourselves as others see us"). This capacity is clearly linked to the ability to understand mental states (e.g., beliefs, knowledge, and intentions) of others, that is, theory of mind or mentalizing. Recent research has shown that mentalizing deficits may substantially contribute to insight impairment in schizophrenia.[9] This effect could be further examined in the broader context of patient's failures in metacognition, i.e. the general ability to think about thinking, and their relationships with insight impairment in schizophrenia. Mentalizing and introspection are closely related developmentally and it is yet unclear which one is the primary ability: we are able to understand others and then apply this understanding to ourselves or we are able to reflect on ourselves and then apply this reflection to others.

A recent line of research in schizophrenia is based on the distinction introduced by Beck et al[10] between clinical insight (i.e., awareness of illness) and cognitive insight, which describes a metacognitive ability, specifically patients' flexibility towards their beliefs, judgements and experiences. The self-report Beck Cognitive Insight Scale (BCIS) examines two sub-

components: self-certainty, assessing overconfidence about being right (e.g. "I know better than anyone else what my problems are"), and self-reflectiveness, assessing willingness to accept external feedback and recognition of dysfunctional reasoning style (e.g. "Some of the ideas I was certain were true turned out to be false"). Cognitive insight in this form describes two related but distinct aspects of metacognition in patients with psychosis, differentially associated with clinical insight, symptoms, treatment outcomes, and functioning.[11] Another method for assessment of similar metacognitive skills also used in schizophrenia is a scale (Metacognition Assessment Scale – Abbreviated, MAS-A) that is administered through a specific interview and examines the capacities of self-reflectivity, understanding of the other individuals' mental states, and using metacognitive knowledge to respond to psychosocial challenges. Lysaker and colleagues found recently that metacognitive deficits assessed with MAS-A predict impaired insight in schizophrenia independent of symptoms.[12] It is questionable whether BCIS and other methods used so far to assess self-reflection in psychoses are valid and useful for patients with non-psychotic disorders.[11] However, the metacognitive conceptualization of insight might contribute to a new research framework for insight impairments across mental disorders.

According to this approach, poor insight is in part a failure of self-reflection, i.e. the process by which we synthesize and comprehend ideas about ourselves. This may be due to general deficits in metacognitive abilities (self-reflectivity, mentalizing) or may represent limited, domain-specific, or transient dysfunctions in metacognitive processes. Insight has to be thought of as a relational concept, that is insight into something: insight into illness, current syndrome, specific symptoms, pathological personality traits, social difficulties etc.[1,3] In an integrated model of insight across mental disorders, aspects of metacognition interacting with multiple other (clinical, neurocognitive, emotional, and social) factors determine patient's ability to correctly process information into self-awareness. The identification of these factors and their interactions may be a fruitful field in the research of insight.

Key words: Cognitive insight, social cognition, metacognition, introspection, self-reflectivity.

G. Konstantakopoulos

First Department of Psychiatry, University of Athens, Eginition Hospital, Athens, Greece & Department of Psychosis Studies, Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK

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