Chapter 5

Insight in Psychosis: An Integrated Perspective

Starlin Vijay Mythri and Johann Alex Ebenezer

Additional information is available at the end of the chapter

http://dx.doi.org/10.5772/intechopen.79368

Abstract

Insight in psychosis is a multidimensional concept with each component being influenced by various biological, individual and cultural factors. The study and understanding of such a concept needs to be done at various levels and with needed emphasis on the personal and interpersonal aspects of the people suffering with psychotic disorders, as this is routinely neglected in the clinical discourse in favor of reductionist biological models. An adequate understanding of the nature of human person should undergird a complex effort like the inquiry into the higher concepts of human experience such as delusion and insight into illness, which in turn should guide the therapeutic, administrative and legal management of people with psychotic illness.

Keywords: insight, psychosis, jaspers, psychopathology, neuroscience

1. Introduction

Psychosis can be a devastating personal experience due to its ability to rob a person of his self determination and control on his behavior. In the interpersonal context it can damage trust in the relationship and diminish the familiarity between the healthy and the affected person, giving rise to interpersonal negative criticism and can even lead to a complete loss in a relationship. In this background how a person suffering with psychotic disorders reflects on his illness and how he interacts with treating team or the legal system with that self-understanding becomes important. The ability of a person to reflect upon his illness is called Insight into illness (psychotic illness in this case).

In this chapter we will chart a historical and conceptual development of the concept of insight in psychosis and how brilliant people throughout history interacted with this concept and its implications. Later we will look at the current neurobiological and socio-cultural perspectives

and outline the need for an integrated view of the concept especially in the background of the nature of human person. We will end the chapter with an attempt to see how far we understand this concept, as well as what the unanswered questions are which would benefit from further study.

2. History of the concept

The concept of Insight in psychosis or the lack of it, did not receive much attention till mid nineteenth century due to its close association with the concept of delusion, so much so that loss of insight was part of the definition of insanity. Two empirical factors [1] that brought about the need for an investigation of this concept were:

1. episodic nature of certain forms of insanity, and
2. incomplete insanity or monomania, in which there was the impairment of specific faculties of the mind and not a global impairment.

Both these factors lead to the assumption that there might be some forms of insanity which can be called Partial Insanity. The idea of Incomplete Insanity in the eighteenth and early nineteenth centuries had to fight the prevalent idea put forward by John Locke of an indivisible or simple mind. This idea was challenged with the help of Gall's Phrenology which divided the brain according to anatomical parts with specific functions and Thomas Reid's Common sense theory of mind which suggested that mind has separable components like will, emotion, etc. After this there was a significant change in the discourse of Insanity with talk of "emotional" insanities and "volitional" insanities.

Partial insanity and the related ideas about specific faculties of the mind therefore led to the birth of an idea of insight as something to be studied and understood in its own right, separate from the concept of mental illness. There was understandable resistance for such a concept because of its far reaching implications on legal responsibility of the people with mental illness. In 1869, an important conference was convened by the Société Médico-Psychologique to inquire into the legal questions raised by the partial insanity and the nature of a person's awareness about his mental illness. Some of the important observations in that conference and subsequent scientific debates were: (1) fair reasoning capacity in an ill person does not always mean that he is aware of his illness; (2) some people who were aware of their illness suggested that they were powerless to prevent few behaviors related to their illness; (3) awareness of mental illness or its symptoms does not mean that the ill person has freedom of choice with regard to the resultant behavior. These issues will be important when insight is discussed in the context of coercion and legal responsibility.

From then on the discussion went in two different streams of thought. On the one hand alienists and prominent biological psychiatrists of the late nineteenth and early twentieth century like Kraepelin, Maudsley, Despine and Lewis spearheaded the view that the insane cannot have insight or judgment about their illness. On the other hand, Dilthey's concept of Human Sciences and Husserl's phenomenology, which later influenced Karl Jaspers, fostered another view that insight or patient's judgment about their illness is dynamic and is related to deeper concepts like that of a person's self.

Another important aspect in the development of the idea of insight into psychosis was the use of different terms in different European countries. For example, Germanic languages like German and English used terms like Einsicht, Insight or Introspection which encouraged a narrow view that the concept of insight is a circumscribed notion and is separable from the larger concepts of mind, consciousness or the self. The French, by contrast, lack a specific term and so used the word "Conscience," which had a wider meaning encompassing consciousness, self-knowledge and introspection. This led to differences in the way the concept of insight was discussed in the French scientific literature compared to that in the Anglophone or German scientific literature.

3. Current perspectives on insight in psychosis

Over the past two decades, there is a resurgence of interest in the concept of Insight in psychosis. This might be due to its relevance with regards to treatment adherence, long term prognosis, psychological management of psychotic symptoms, as well as use of coercion in treatment and legal responsibility of people with psychotic disorders. The understanding of the concept has greatly evolved from the initial categorical yes or no assessment in studies like International Pilot Study of Schizophrenia [2] and assessment schedules like Present State Examination [3] to a multidimensional construct covering various aspects of Insight.

The initial multidimensional construct by David [4] was characterized by three aspects of awareness of being mentally ill, awareness of pathological nature of symptoms and acceptance of treatment. Though this approach was lauded by various researchers who further expanded it, many others from the anthropological perspective have deemed it as a biomedical approach which favors a reductionist biological understanding of the concept of Insight and mental illness.

4. Problems with the concept of insight in psychosis

Insight in psychosis is a difficult concept to define within a biomedical model due to various factors which are listed by Fulford [5] as:

1. Insight, like the concept of Time, is a higher level concept which is easier to use than to define.
2. Insight is related with particular features of mental illness like delusions, hallucinations and thought alienation phenomena and not to other features.
3. Delusion is a psycho-pathologically and ethically central feature in mental illness.
4. Delusion has a conceptual range of forms comparable to normal human reason.

When we consider the usage of the concept of insight we find that the distinction between psychotic and nonpsychotic has wide clinical use and is legally important. Within the symptoms of psychosis, it is delusions which are perhaps most closely associated with insight and therefore the understanding of insight has similar conceptual limitations as the understanding and definition of delusion.

5. Neurobiology and metacognition research

Metacognition is the ability of the human mind to reflect, look upon and influence itself. In the fourth century AD, Saint Augustine in his popular Confessions [6] ponders about the meta-memory, a concept akin to metacognition that, "When, therefore, I remember memory, then memory is present to itself by itself, but when I remember forgetfulness then both memory and forgetfulness are present together – the memory by which I remember the forgetfulness which I remember." And in his Allgemeine Psychopathologie [7] Karl Jaspers also similarly writes, "I am not only conscious in the sense of having certain inner experiences, but I am turned back on myself – reflected back – in the consciousness of self. In the course of this reflection, I not only come to know myself, but I also influence myself." Though, as shown, this faculty of human mind was known from ancient times, it was not neuro-biologically investigated.

Over the last decade, interesting research into the neuroscience of self and self-reflection has opened new avenues for the understanding of the human mind and perception of changes within the self. In the study of the concept of insight in psychosis these are relevant findings as they pertain to normal and abnormal self-reflection. We will point out few prominent and replicated functional MRI findings using the Beck Cognitive Insight Scale [8], though these were done on small sample sizes and did not account for the effects of duration of illness and use of antipsychotic medication.

1. Cortical midline structures (CMS) comprising of medial prefrontal cortex, anterior and posterior cingulate cortex are seemingly associated with self-reflection. Researchers [9–12] have found that in people with schizophrenia, the anterior portion of CMS was often functional when self-appraisal was contrasted with other-appraisal and also that within the anterior portion of CMS, the ventro-medial prefrontal cortex is more correlated with information relevant to self than the dorso-medial prefrontal cortex. This suggests that CMS deficits might lead to people with schizophrenia having problems with distinguishing self from others.

2. Other researchers [13, 14] have shown an anterior to posterior shift in CMS activity in a similar group of people with schizophrenia during self and social reflection tasks. An associated observation was that there was also a functional connectivity change between anterior and posterior cingulate cortex.

3. Symptom unawareness component of insight was observed to have widespread brain activation including CMS areas compared to symptom misattribution component which was localized to specific brain regions [13]. This finding is interesting due to its implications on the relationship between the various components in the concept of insight in psychosis.

4. There was a positive association between posterior CMS activation and cognitive insight in people with schizophrenia but not in those with bipolar disorder with psychotic symptoms [15]. This particular finding has to be replicated.

Unlike the earlier research which made multiple unsuccessful attempts at finding a specific executive deficit associated with the whole concept of insight as was suggested by Aubrey Lewis at the beginning of the twentieth century [16], the above mentioned research correlates more with specific components of insight rather than a unitary whole. However, caution

needs to be employed in view of limitations of above mentioned research and also due to the fact that this studies only the brain correlates which may be down-stream events and their interpretation as to whether they are causes or effects depends on the worldview espoused, biomedical or any other.

6. Cultural critique of insight

Markova and Berrios [17, 18] have suggested three broad ways that the field of mental health conceptualizes problems with insight:

(1) Insight as impaired awareness, i.e., a neurobiological deficit in awareness due to the psychotic disease process. This is biological psychiatry's position on the concept of insight.

(2) Insight as self-deception, i.e., a psychodynamic defense mechanism that needs to be overcome in therapy. This view is a broad understanding not limited to psychosis, and is more relevant in the neurotic conditions and those requiring psychotherapy.

(3) Insight as misattribution, i.e., cognitively attributing symptoms to different causes.

Socio-cultural critics of the concept of insight take the third position, and argue that a person who is suffering with psychotic illness may attribute problems to different causes. However as long as the person is able to construct a meaningful explanation of his symptom experience and integrate the psychotic experience into his life, he should be considered to have insight into illness [18]. Insight should not be restricted to just a biomedical explanation, as that explanation itself is argued to be a socially- constructed model among those who subscribe to a western, individualist, post-enlightenment and biologically reductionist position.

A few workers have suggested socio-cultural modifications to the multidimensional model of insight [19], for example accepting any kind of help including nonmedical help should qualify as presence of certain form of insight. As the causal explanations of mental illness are contested across cultures, anthropological critics argue for a wider and an inclusive understanding of the concept of mental illness and a suffering person's judgment about it.

One other aspect of the cultural critique of insight in psychosis is the consistent observation that the prognosis of schizophrenia is demonstrably better in developing countries [2]. These cultures are also often less likely to espouse the biomedical models of causation and treatment by default. The role of strong family systems has long been postulated to be a contributor to the better prognosis in developing countries, and it is worth considering the role of family beliefs in impacting the patient's insight into his illness.

7. Nature of the human person

The nature of Human being has been discussed since antiquity. Mind–body relationship and nature of the human mind has given rise to numerous debates. All the research discussed till now from a biomedical viewpoint has presented empirical facts as opposed to the evaluative

dimension of human person. Therefore it is important to understand the personalist emphasis provided by Dilthey and Husserl. Personalism [20] as a distinctive philosophy which emphasizes the centrality of personhood of human being and his dignity, has been explored prominently by Immanuel Kant and later by people who were influenced by him.

Wilhelm Dilthey [21] notably distinguished natural sciences from human sciences emphasizing that the approach needed for studying distinctly human aspects of men and women has to be different from the methods of natural science. He suggested due to the dual (i.e., biological and psychological) aspects of human nature it has to be studied from both an "erklaren" (causal explanation) perspective and "verstehen" (empathic understanding) perspective. While Erklaren-perspective deals with descriptive aspect of symptoms and tries to give causal explanation, Verstehen-perspective describes the meaningful nature of human experience and therefore is more akin to the personal aspects. Dilthey's ideas, as mentioned earlier, exercised tremendous influence on Jasper's psychopathology. Buber [22], another personalist contemporary of Dilthey, distinguished between two types of relationships possible for us, i.e., the "I-You" relationship and the "I-it" relationship. The "I-You" relationship emphasizes the uniqueness of human personal encounters with other personal beings which is not comparable to a human encounter with an impersonal object (an "it").

Lastly, Wojtyla [23] defined a person as a being towards which the only adequate attitude is one of love and respect. It is in this personalist background, Fulford claims that delusion (and by implication the related concept of insight) is a failure of practical-reason of the person rather than a cognitive deficit [24]. Practical reasoning is the opposite of theoretical reasoning which is concerned with facts, cause–effect relations and impersonal objective explanations, and is the reasoning needed in the practical life to subjectively evaluate choices for actions and therefore is related to values. So, according to Fulford there is a failure of practical reasoning which presents as wrong choices and actions in people with psychotic disorders. We here introduce the alternative viewpoint which emphasizes the regard for the personhood of a human being in the discussion of the Insight in psychosis.

8. Discursive psychology and intersubjectivity

In second half of the last century, there were numerous voices from humanities and even from within the natural sciences decrying the reductionist anthropology in scientific psychiatry. The coercive practices of psychiatry in this context were discussed as violations of human rights and dignity. For example, research suggests that involuntary treatment is overused in some parts of the world based on narrow biomedical models of insight [25] and historically totalitarian governments like the Soviet Union have used (as part of their "official" classifications) unscientific labels like "sluggish schizophrenia" with the alleged symptom of "inflexibility of ideas" to incarcerate political dissenters.

This movement aimed at broadening the narrow emphasis of biological psychiatry was enhanced by the developments in the study of language and discourse. Discourse analysis and the related field of discursive psychology [26] regard human verbal interaction as a performative act within a context, i.e., language is used not only to *describe* internal and external

reality but also is used to *perform* or achieve certain ends based upon the context within which such an interaction happens. Discursive psychology helps us understand the clinical context in which an assessment of insight happens, for example a delusion or a thought insertion is attributed differently by the clinician and the suffering person. Language therefore is used to describe what the patient is experiencing as well as to interpret and inform his beliefs about the cause of the symptoms in the clinical context. It gives us tools to unravel the intended goals of the person with psychotic illness when he communicates his judgment about the illness.

We are also enriched by the concept of narrative insight [27] which tries to understand the insight of the person suffering from psychosis as a tool by which she tries to make sense of her illness. These concepts of human discourse and narrative add complexity to the concept of insight while emphasizing the personal and interpersonal aspects during the assessment and management of people with psychotic illness.

9. Integrated view of insight in psychosis

Considering the various arguments from neuroscience and anthropology, David [28] accepts that the "acceptance or awareness of the mental illness" component of his model can be influenced widely by the pre-existent interpretative frameworks in the suffering person's culture while the "acceptance of the kind or duration of treatment" component may also be depended more on the pre-morbid personality of the suffering person and may not be related to his or her neurobiological deficits due to the illness. Only the component of "acceptance or the relabeling of experience as pathological" may be closely related to the cognitive deficits due to the neurobiological disease process which may be consistent across cultures. This last point is corroborated by the empirical evidence from the developing world [29], that people with schizophrenia when assessed with multidimensional rating scales of insight more often accept the pathological nature of their symptoms but are hesitant to accept the biomedical model of the mental illness as a whole.

When we hold both sides of the argument (the biological and the personal) together it helps us to better understand the complexity of the concept of insight in psychosis. Such a composite view is presented in Jasperian phenomenological psychopathology (with its emphasis on "erklaren" and "verstehen" perspectives in investigating psychopathology), which is more holistic and person-centered than the narrow reductionist focus on symptoms in Kraepelinian descriptive psychopathology. The Jasperian model allows the impersonal disease to be combined with the personal illness, and the biological deficit to be combined with the failure of reasoning which evaluates personal choices and action [30]. Such an integrated view is more reflective of the kind of being that we are discussing about, i.e., the mystery of how the neurobiological and psycho-spiritual components come together in the complex entity we call the Human Person.

The current chapter through a historical, neurobiological and personalist review of the concept of insight, however, raises many questions, while bringing some clarity to the discussion. Some of the questions are:

1. In the psychological capacity assessment by Appelbaum et al. called McCAT [31], the psychotic loss of capacity is considered an "appreciation disorder." This is distinct from the reasons for the loss of capacity in other illnesses like dementia, which are due to memory and reasoning defects. So the question remains as to what is the relation between delusional loss of rationality and the loss of rationality due to cognitive defects?

2. The concept of delusion is intimately related to the loss of insight, but the difficulty in precisely defining and delineating it is an added problem. Delusion is thought to be pathological either due to problems in perception or in logical reasoning, which purportedly displays a "loss of contact with reality." But there are research studies which report that it is difficult to demonstrate a problem with either aspect in patients with delusions: the posited perceptual basis for a delusion is internal and therefore cannot be accurately measured externally, while problems with logical reasoning are not observed [32]. So, what is the demonstrable criterion by which delusion can be incontrovertibly established? A definite answer to this question has thus far been elusive, even though delusions are certainly reliably assessed, diagnosed and treated in clinical practice regularly. A related—and even more clinically challenging—question is by what criteria can we differentiate a delusion from a strongly held religious, scientific or any other over-valued belief?

3. What are the relational dynamics and pitfalls of the inter-personal assessment of loss of insight between the clinician and the person with psychotic illness? And what are the borderlands between providing care and unethical coercion?

Others who want to delve deeper may want to explore the relation between delusion, belief, discourse, power relations and the nature of reality. Though interesting, they are beyond the purview of the discussion of the concept of insight in psychosis.

10. Conclusion

Historically, the concept of insight in psychosis has evolved over time from being part of the very definition of psychosis to being an independent, modifiable aspect of the experience of a patient with psychosis. There has also been an evolution in the understanding of insight from a unitary to a multidimensional construct, with each component being influenced by various biological, individual and cultural factors. The study and understanding of such a complex, multidimensional concept needs to be carried out at various levels and with needed emphasis on the personal and interpersonal aspects of the people suffering with psychotic disorders, aspects that are routinely neglected in the clinical discourse in favor of reductionist biological models.

While exciting neurobiological research seems to indicate that certain aspects of insight in psychosis may be biologically driven, it can no longer be justifiably considered a unitary construct. Individual and sociocultural factors play a key role in insight. "Acceptance of mental illness as the cause of symptoms" and "acceptance of treatment" are both factors that may be significantly colored by one's pre-morbid personality, worldview and cultural background. A patient who is able to recognize symptoms as being abnormal experiences and attempts to organize his experience in a meaningful way leading to help-seeking should be considered as having good insight into his illness even if the explanation and treatments he espouses differ from biomedical ones.

An imposition of biomedical models into the definition of insight may not only alienate patients from other cultural backgrounds from approaching treatment, it may also impede accurate clinical judgment by making the assessment of this crucial aspect of illness incomplete.

Fundamental to any effort to understand higher aspects of human experience (such as delusions and insight into illness) is an adequate understanding of the nature of human personhood. Taking after Kraepelinian descriptive psychopathology, biological psychiatry has tended towards reductionist understandings of personhood that emphasize neurobiology and symptoms of illness. We suggest that the more holistic Jasperian phenomenological approach to psychopathology which emphasizes both the "erklaren" (descriptive and causal explanations) and "verstehen" (empathic understanding) aspects of psychopathological assessment is a better reflection of the complexities that make up the human condition. Such a holistic, integrated understanding of the concept of insight in psychosis would in turn guide the therapeutic, administrative and legal management of people with these debilitating illnesses.

Author details

Starlin Vijay Mythri[1]* and Johann Alex Ebenezer[2]

*Address all correspondence to: starlinvijay@yahoo.co.in

1 Asha Bipolar Clinic, Asha Hospital, Hyderabad, Telangana, India

2 Distance Education Unit, Christian Medical College, Vellore, Tamilnadu, India

References

[1] Berrios G, Markova I. Insight in the psychoses: A conceptual history. In: Amador XF, David AS, editors. Insight and Psychosis - Awareness of Illness in Schizophrenia and Related Disorders. 2nd ed. New York: Oxford University Press; 2004. pp. 31-50

[2] Sartorius N, Shapiro R, Jablensky A. The international pilot study of schizophrenia. Schizophrenia Bulletin. 1974;**1**(11):21-34

[3] Present State Examination-Oxford Reference [Internet]. [cited May 17, 2018]. Available from: http://www.oxfordreference.com/view/10.1093/oi/authority.20110803100343713

[4] David AS. Insight and psychosis. The British Journal of Psychiatry: The Journal of Mental Science. 1990;**156**:798-808

[5] Fulford K. Insight and delusion: From jaspers to Kraepelin and back again via Austin. In: Amador XF, David AS, editors. Insight and Psychosis - Awareness of Illness in Schizophrenia and Related Disorders. 2nd ed. New York: Oxford University Press; 2004

[6] Augustine A. Confessions and enchiridion, newly translated and edited by Albert C. Outler - Christian Classics Ethereal Library [Internet]. Grand Rapids, MI, USA: Christian Classics Ethereal Library; [cited 2018 May 17]. 10.16. Available from: http://www.ccel.org/ccel/augustine/confessions

[7] Jaspers K. Psychological preface - Phenomena of self-reflection. In: General Psychopathology. Johns Hopkins Paperbacks Edition. Baltimore, Maryland, USA: The Johns Hopkins University Press; 1997. p. 131

[8] Beck AT, Baruch E, Balter JM, Steer RA, Warman DM. A new instrument for measuring insight: The Beck cognitive insight scale. Schizophrenia Research. 2004;**68**(2-3):319-329

[9] van der Meer L, Costafreda S, Aleman A, David AS. Self-reflection and the brain: A theoretical review and meta-analysis of neuroimaging studies with implications for schizophrenia. Neuroscience and Biobehavioral Reviews. 2010;**34**(6):935-946

[10] Bedford NJ, Surguladze S, Giampietro V, Brammer MJ, David AS. Self-evaluation in schizophrenia: An fMRI study with implications for the understanding of insight. BMC Psychiatry. 2012;**12**:106

[11] David AS, Bedford N, Wiffen B, Gilleen J. Failures of metacognition and lack of insight in neuropsychiatric disorders. Philosophical Transactions of The Royal Society B Biological Sciences. 2012;**367**(1594):1379-1390

[12] David AS, Bedford N, Gilleen J, Greenwood K, Morgan K, Wiffen B. The etiology of lack of insight in schizophrenia. Schizophrenia Bulletin. 2011;**37**(Suppl 1):14

[13] Shad MU, Keshavan MS. Neurobiology of insight deficits in schizophrenia: An fMRI study. Schizophrenia Research. 2015;**165**(2-3):220-226

[14] Holt DJ, Cassidy BS, Andrews-Hanna JR, Lee SM, Coombs G, Goff DC, et al. An anterior-to-posterior shift in midline cortical activity in schizophrenia during self-reflection. Biological Psychiatry. 2011;**69**(5):415-423

[15] Zhang L, Opmeer EM, Ruhé HG, Aleman A, van der Meer L. Brain activation during self- and other-reflection in bipolar disorder with a history of psychosis: Comparison to schizophrenia. Neuro Image: Clinical. 2015;**8**:202-209

[16] Lewis A. The psychopathology of insight. The British Journal of Medical Psychology. 1934;**14**(4):332-348

[17] Marková IS, Berrios GE. The meaning of insight in clinical psychiatry. The British Journal of Psychiatry. 1992;**160**:850-860

[18] Kirmayer LJ, Corin E, Jarvis GE. Inside knowledge: Cultural constructions of insight in psychosis. In: Amador XF, David AS, editors. Insight and Psychosis - Awareness of Illness in Schizophrenia and Related Disorders. 2nd ed. New York: Oxford University Press; 2004. pp. 197-229

[19] Saravanan B, David A, Bhugra D, Prince M, Jacob KS. Insight in people with psychosis: The influence of culture. International Review of Psychiatry (Abingdon, England). 2005;**17**(2):83-87

[20] Williams TD, Bengtsson JO. Personalism. In: Zalta EN, editor. The Stanford Encyclopedia of Philosophy [Internet]. Summer 2018. Stanford, CA, USA: Metaphysics Research Lab,

Stanford University; 2018. Available from: https://plato.stanford.edu/archives/sum2018/entries/personalism/

[21] Makkreel R, Dilthey W. In: Zalta EN, editor. The Stanford Encyclopedia of Philosophy [Internet]. Fall 2016. Stanford, CA, USA: Metaphysics Research Lab, Stanford University; 2016. Available from: https://plato.stanford.edu/archives/fall2016/entries/dilthey/

[22] Buber M. Internet Encyclopedia of Philosophy [Internet]. [cited May 17, 2018]. Available from: https://www.iep.utm.edu/buber/

[23] Wojtyla K. Love and Responsibility. Revised ed. San Francisco: Ignatius Press; 1993. 319 p

[24] Fulford K. Completing Kraepelin's psychopathology: Insight, delusion and the phenomenology of illness. In: Amador XF, David AS, editors. Insight and Psychosis. 1st ed. New York: Oxford University Press; 1998. pp. 47-65

[25] Kim Y. Japanese attitudes towards insight in schizophrenia. In: Amador XF, David AS, editors. Insight and Psychosis - Awareness of illness in schizophrenia and related disorders. 2nd ed. New York: Oxford University Press; 2004

[26] Gibbs GR. Discourse Analysis Part 1: Discursive Psychology-You Tube [Internet]. 2015 [cited May 17, 2018]. Available from: https://www.youtube.com/watch?v=F5rEy1lbvlw

[27] Tranulis CS, Freudenreich O, Park L. Narrative insight: Rethinking insight in psychosis. International Journal of Culture and Mental Health. 2009;**2**(1):16-28

[28] David AS. The clinical importance of insight: An overview. In: Amador XF, David AS, editors. Insight and Psychosis - Awareness of Illness in Schizophrenia and Related Disorders. 2nd ed. New York: Oxford University Press; 2004. pp. 359-392

[29] Tharyan A, Saravanan B. Insight and psychopathology in schizophrenia. Indian Journal of Psychiatry. 2000;**42**(4):421

[30] Fulford K, Broome M, Stanghellini G, Thornton T. Looking with both eyes open: Fact and value in psychiatric diagnosis? World Psychiatry. June 2005;**4**(2):78-86

[31] Grisso T, Appelbaum PS. Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals. Oxford, New York: Oxford University Press; 1998. 224 p

[32] Georgaca E. Reality and discourse: A critical analysis of the category of delusions. The British Journal of Medical Psychology. 2000;**73**(2):227-242

IntechOpen