THE RELATIONSHIP BETWEEN DEGREE OF INSIGHT INTO ILLNESS AND LEVEL OF CARE AMONG CLIENTS WITH PSYCHOTIC DISORDERS

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THE RELATIONSHIP BETWEEN DEGREE OF INSIGHT INTO ILLNESS AND LEVEL OF CARE AMONG CLIENTS WITH PSYCHOTIC DISORDERS

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ABSTRACT

The construct of insight is considered highly relevant to mental health professionals who treat individuals with psychotic disorders. While empirical research on insight and its relationship to different levels of care has increased recently, the vast majority of previous research in this area has primarily focused on insight and its association with hospitalization-related outcomes. Research comparing insight to different levels of care (i.e., outpatient, hospitalization, and residential) is thus far nonexistent. The purpose of this study was to investigate whether insight differed among psychotic clients in an outpatient versus inpatient treatment setting, and whether degree of insight related to the need for an inpatient admission. One hundred seventy psychotic clients were administered the Scale to Assess Unawareness of Mental Disorder (SUMD) and the Functional assessment Rating Scale (FARS). One-way multivariate analysis of variance results indicated that there was a statistically significant difference in insight between clients in outpatient versus inpatient levels of care. A multiple regression analysis showed that insight into the need for treatment significantly predicted current need for an inpatient admission. Implications and recommendations for clinical practice, counselor education and supervision, and future research are outlined.
DEDICATION

This dissertation is dedicated to my husband Keith, my parents Vincenzo and Lucia, and Brother Tony. This dissertation is also dedicated to the memory of my Grandfathers Floriano and Pasquale. Finally this dissertation is dedicated to all those who suffer from psychotic disorders. May each contribution of research bring us closer to better understanding this disease and finding better interventions to ease your suffering. For those clients I have worked with over the years, thank you for allowing me into your lives and into your hearts.
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CHAPTER I
INTRODUCTION

Until the 1990s, insight into psychotic disorders (or awareness of illness) had received little systematic examination (David, 1990a). However, the phenomenon of insight has been considered highly relevant and critical to mental health professionals, who treat individuals with psychotic disorders. Lack of insight is a distinctive feature of psychotic disorders (Amador & David, 1998). Understanding the phenomenon of insight in psychosis is critical given the impact awareness of illness has on client outcomes.

The construct of insight can be a valuable tool for clinicians working with clients who have psychotic disorders. This insight can aid clinicians in gaining a better understanding of clients’ awareness of having a mental illness. Clinicians can plan appropriate interventions to meet the client’s unique treatment needs, assess whether or not clients will understand the benefits of treatment, and predict which clients are more likely to adhere to treatment. Ultimately, this knowledge is what leads clinicians to make treatment and level of care decisions on behalf of clients if they are unable to make those decisions for themselves. Therefore, insight is a critical tool for clinicians to utilize in making clinical recommendations or determinations.

Insight or lack of insight not only impacts the clinical treatment recommendations and decisions that clinicians make, but also it impacts clients’ freedom if clients are placed in more restrictive settings (e.g., hospital settings). Results from research have
established relationships between impaired insight, lack of adherence to treatment, and medication noncompliance (Kemp & David, 1996b) which oftentimes leads to a relapse and the need for more restrictive care. If clinicians could intervene before this occurs, they may be able to apply prevention strategies to avoid a relapse and the need for more restrictive care. This would also drastically reduce the cost of more restrictive care to an already overburdened healthcare system.

While a vast amount of empirical research on the construct of insight has been conducted in the past 10 to 15 years, research has predominantly focused on insight and its relationship to specific variables (e.g., symptomatology, outcomes, global functioning, psychosocial functioning, treatment adherence, etc.) usually not including treatment settings (Amador & Strauss, 1993; Buckley, Hasan, Friedman, & Cerny, 2001; Fenton, Blyler, & Heinssen, 1997; Lysaker, Bell, Bryson, & Kaplan, 1998; Schwartz, 1998a; Schwartz, Cohen, & Grubaugh, 1997). Few research studies have attempted to ascertain whether insight is related to settings such as hospitalizations and post-hospitalizations (Kelly et al., 2004; Smith et al., 2003). To date, there has been no research comparing insight to different levels of care (i.e., outpatient, hospitalization, and residential). There is also no current research available examining the construct of insight as a screening measure to help clinicians make level of care determinations.

Introduction to Psychotic Disorders

There are six distinct types of psychotic disorders, including: Brief Psychotic Disorder, Delusional Disorder, Schizoaffective Disorder, Schizophrenia, Schizophreniform, and Shared Psychotic Disorder. Psychotic disorders are a group of serious illnesses that affect the mind. These illnesses alter a person's ability to think
clearly, make good judgments, respond emotionally, communicate effectively, understand reality, and behave appropriately. When symptoms are severe, people with psychotic disorders have difficulty staying in touch with reality and often are unable to meet the ordinary demands of daily life. The major symptoms of psychotic disorders are positive psychotic symptoms, or delusions and hallucinations (American Psychiatric Association [APA], 2000). Other symptoms of psychotic disorders include: disorganized or incoherent speech, confused thinking, slowed or unusual movement, loss of interest in personal hygiene and activities, problems in relationships at school and work, cold or detached manner with an inability to express emotion.

Psychotic disorders are considered to be the most expensive mental illnesses in terms of costs per client, accounting for 2.5% of national health expenditure during the 1980s and 1990s in the United States (Knapp, 1997). However, cost figures only represent expenditures for treated clients with Schizophrenia and other psychotic disorders within the national health care systems. Many individuals, diagnosed and undiagnosed, go untreated due to a combination of factors from stigma, homelessness, denial of symptoms, to lack of insight into the mental disorder.

The most frequent and most important group of psychotic disorders is Schizophrenia. Although Schizophrenia is not a very common disease, it is among the most burdensome and costly illnesses worldwide. In the United States, Schizophrenia has a lifetime prevalence rate of 1%, that is, approximately one out of 100 persons in the general population will develop Schizophrenia at some point (APA, 2000). The lifetime prevalence rate for all psychotic disorders combined is approximately 2% (APA). The life expectancy for individuals, diagnosed with Schizophrenia, is reduced by
approximately 10 years, mostly as a consequence of suicide. Even though the course of illness today has better prognosis than in the past, due to newer medications and treatment modalities, it is still only a minority of those affected who fully recover (Rossler, Salize, van Os, & Riecher-Rossler, 2005).

Schizophrenia ranks among the top 10 causes of disability in developed countries worldwide (World Health Organization, [WHO], 2001). More than two million Americans are affected by Schizophrenia in any one given year, and only one in five recovers completely. The illness typically develops in late teens or early twenties. Most people with Schizophrenia continue to suffer chronically or episodically throughout their lives. Even between bouts of active illness, lost opportunities for careers and relationships, stigma, residual symptoms, and medication side effects often plague those with the illness. One in every 10 people, diagnosed with Schizophrenia, eventually commits suicide (National Institute of Mental Health, 2002, para. 3).

According to the Global Burden of Disease study, Schizophrenia causes a high degree of disability which accounts for 1.1% of disability-adjusted life years and 2.8% of years lived with disability worldwide. In the World Health Report (WHO, 2001), Schizophrenia is listed as the eighth leading cause of disability worldwide in the age group 15-44 years. The overall United States cost of treating Schizophrenia is estimated to be $62.7 billion with $22.7 billion excess in direct healthcare cost ($7.0 billion outpatient, $5.0 billion drugs, $2.8 billion inpatient, $8.0 billion long-term care) (Wu et al., 2005). Schizophrenia is a debilitating illness resulting in significant costs, not only for the individual, but for society as well. The burden of Schizophrenia is large and multifaceted. There are direct costs of providing care for individuals with Schizophrenia
as well as indirect costs. Indirect costs encompass the loss of productivity through impairments, disability and premature death, burden on caregivers, as well as legal problems (Rossler et al., 2005).

Schizophrenia and other psychotic disorders have a large impact, not only on individuals, but on families, caregivers, and the communities at large. Psychotic disorders lead to marked impairment in individuals’ lives often including long term treatment, multiple hospitalizations, psychosocial impairment, loss of employment, and reduced quality of life. Individuals suffer primarily from distressing symptoms of the disorder. In addition, these individuals may lack self-esteem because they are unable to participate in work and leisure activities, not only as a result of the disability but also because of stigma and discrimination. Often, these individuals also worry about being a burden to their families and other caregivers (Rossler et al., 2005). The burden of families ranges from emotional reactions to the illness, stress of coping with behaviors resulting from the illness, disruption of household routines, restriction of social activities, and economic constraints (Rossler et al., 2005). Often times, families and caregivers do not have the financial resources or supports to care for individuals affected by this disease, thus placing more strain on the individuals and families impacted by Schizophrenia.

Introduction to Insight and Psychosis

A common phenomenon among psychotic disorders is poor insight. For example, Schwartz (1998c) explains that “one of the most common and puzzling features of Schizophrenia is lack of awareness of mental disorder” (p. 3). In fact, it was noted early in the study of psychosis that poor insight is pathognomonic to or characteristic of these
disorders (Carpenter, Bartko, Carpenter & Strauss, 1976; WHO, 1973). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (APA, 2000) states that “a majority of individuals with Schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness itself rather than a coping strategy. It may be comparable to the lack of awareness of neurological deficits seen in stroke, termed Anosognosia” (p. 304). Therefore, although poor insight is not one of the diagnostic criteria for any specific psychotic disorder, it may be an associated symptom of psychosis. Psychotic clients may, as a consequence of developing a severe thought disorder, lose some or all conscious awareness of the disorder itself. Although poor insight is evident in most psychotic disorders, this phenomenon seems particularly prevalent in Schizophrenia (Amador, Flaum, Andreasen, & Strauss, 1994; Fennig, Everett, Bromet, & Jandorf, 1996). These assertions are supported by empirical findings by Pini, Cassano, Dell’Osso, and Amador (2001), who found that individuals with Schizophrenia displayed poorer insight relative to individuals with Schizoaffective Disorder. Some writers have even asserted that poor insight should be considered a formal diagnostic feature of psychosis (specifically Schizophrenia) (Amador, Strauss, Yale, & Gorman, 1991; Schwartz, 1998b).

The definition of insight as it relates to psychotic disorders has evolved over the years. The term insight typically denotes, “An understanding of the motivational forces behind one’s action, thoughts, or behaviors” (Flexner & Hauck, 1987, pp. 986-987). In the mental health professions, definitions of insight have historically reflected authors’ underlying theoretical conceptualizations. For example, previous writers have used terms such as sealing over, defensive denial, evasion, and external attribution when attempting
to illustrate the construct of poor insight in psychosis (David, 1990a; McGlashan, Levy & Carpenter, 1975; Wciorka, 1988). Contemporary definitions of the construct of insight are multidimensional. That is, recent authors have argued that insight in psychosis (or the lack thereof) includes several distinct dimensions, all of which impact a client’s awareness of their disorder (Schwartz, 1998c).

The three most common and accepted global dimensions of insight in psychosis are awareness of the mental disorder in general, understanding the social consequences of the disorder, and awareness of the need for treatment. Therefore, good insight into psychosis implies awareness by the client (a) that he or she has a mental disorder which affects reality testing and related life domains (i.e., the way one thinks, feels, and behaves); (b) that symptoms of the mental disorder may result in psychosocial impairments (e.g., relationship problems, occupational difficulties, psychiatric hospitalizations); and (c) that mental health-related treatments are needed to reduce symptoms of illness (e.g., psychotropic medications, psychosocial [i.e., counseling] interventions). Although some authors propose that insight into specific signs and symptoms of psychosis (e.g., hallucinations, delusions) is an important aspect of measuring the phenomenon (Amador & David, 1998), most authors agree that the basis for insight into psychosis is awareness of the three global dimensions outlined above.

The definition of insight used in this study is therefore the conscious recognition by a psychotic client that he or she suffers from a diagnosable mental disorder which has a causal relationship to maladaptive aspects of one’s functioning, resulting in mental health interventions (adapted from Schwartz, 1998c).
Previous studies estimated that between 50% to 80% of psychotic individuals do not believe that they have a mental disorder (e.g., Amador & Gorman, 1998). For example, in 1994 a Schizophrenia and psychotic disorders work group was empanelled by the American Psychiatric Association to revise the DSM. One main objective of this panel was to investigate the prevalence of poor insight in psychotic disorders and to examine its specificity to Schizophrenia (Amador et al., 1994). Results indicated that nearly 60% of individuals with Schizophrenia displayed moderate to severe unawareness of having a mental disorder. Findings also suggested that at least some aspects of poor insight (i.e., severe and pervasive deficits in certain types of self-awareness) are uniquely characteristic of Schizophrenia as compared to other psychotic disorders. This research also provided the first tangible evidence suggesting that although poor insight is common among psychotic clients, it may manifest differently according to the specific type of psychotic disorder in question.

Introduction to Research on Insight and Psychosis

Due to the commonality of poor insight in psychosis, and the broad implications this associated symptom has for diagnosis and treatment of psychotic disorders, researchers have increasingly turned their attention toward investigating this phenomenon. A literature review revealed that empirical research in this area has occurred primarily during the past 15 years. Research studies have increased dramatically particularly during the past decade (Amador & Kronengold, 2004).

Whereas most articles about insight used to rely on nonstandardized clinical anecdotes, there is now a plethora of literature dedicated to the empirical examination of insight in psychotic disorders. However, past research and literature lacked
standardization with respect to research design and measurement (Schwartz, Skaggs, & Peterson, 2000). In the early 1990s, investigations began to develop more reliable and valid methods to assess insight leading to an explosion of new studies that illuminate the role that insight plays in the prognosis, course, and treatment of psychotic disorders.

Although many recent investigations have proposed that insight is a multidimensional phenomenon, many existing assessment methods continue to treat awareness of illness as a unitary concept. Thus, most past assessment tools failed to address the complexities and dimensional nature of the phenomenon (Amador & Strauss, 1993). In the last decade, several valid and reliable scales have been developed to measure insight, and the majority of recent studies have used these rating systems (Husted, 1999). Many authors now seem to view insight as a multidimensional and continuous phenomenon. This view has allowed researchers to evaluate more comprehensively the complex nature of insight to relate it to various signs and symptoms of psychopathology (Amador & Kronengold, 2004; Baier, Murray, & McSweeney, 1998).

Among findings consistently reported, it appears that deficits in insight most often stem from the disorder itself, from brain dysfunction, rather than from defensive coping strategies (APA, 2000). Another common finding is that poor insight is among the best predictors of non-adherence and partial adherence to medication. With non-adherence rates continuing to hover around 50% despite the improved side-effect profiles of second generation antipsychotic medications, increased interest in psychological interventions aimed at either improving insight and/or compliance has flourished (Amador & Kronengold, 2004).
Several studies indicated that global functioning is impeded by lack of awareness of one’s illness (Francis & Penn, 2001; Lysaker & Bell, 1995). Research has found that the less aware that an individual, with Schizophrenia, is of being ill, the more likely he or she may be to decline treatment and experience interpersonal difficulties. Poor insight negatively affects psychosocial functioning, leads to noncompliance with medication regimes, limits psychotherapeutic treatment effectiveness, and reduces treatment outcomes (Amador & Strauss, 1993).

In a study by Schwartz et al. (1997) results showed that greater insight was significantly related to both higher global and specific functioning after long-term treatment. Furthermore, results suggested that poor insight is related to reduced psychosocial functioning before and after treatment, less compliance with medication and treatment regimes, and barriers to the treatment process. In addition, increasing clients’ awareness of the signs and symptoms of Schizophrenia may result in better therapeutic outcome (Schwartz et al., 1997).

Lysaker et al. (1998) investigated the effect of insight on psychosocial functioning and work rehabilitation. Results showed that poor insight was associated with less participation, fewer social skills, and poorer prognosis. Additional studies by O’Connor and Herrman (1993) and Peralta and Cuesta (1994) also found that ratings of poor insight were associated with decreased global functioning.

In addition to the impact on clinical course and prognosis, poor insight has been associated with psychotic clients’ severity of symptoms. In a large scale study conducted as part of the DSM-IV field trials that assessed the nature of the symptom and insight relationship, Amador et al. (1994), found that insight deficits were more pervasive and
severe in Schizophrenia than in Major Depressive and Schizoaffective Disorders. In addition, clients with Schizophrenia, who presented with increased delusions, thought disorders, and disorganized behavior were all modestly correlated with decreased awareness of mental disorders, the social consequences of the mental disorder, and several positive symptoms. In yet another study by Nakano, Takeshi, Iwata, Hasako, and Nakamura (2004), these researchers found that negative symptoms were significantly and negatively associated with insight.

Lack of insight has been linked to both positive and negative symptoms in different client groups (Amador et al., 1994; Buckley et al., 2001). Results of research on level of insight and severity of psychotic symptoms have yielded inconsistent results across studies. While some studies have shown that impairment of insight in individuals with Schizophrenia was positively correlated with the severity of positive symptoms and/or negative symptoms (Buckley et al., 2001; Schwartz, 1998c), other studies found that insight is not associated with psychotic symptoms (Peralta & Cuesta, 1994). Yet, other researchers report that insight is associated with cognitive function, particularly front-executive function (Lysaker & Bell, 1998; Chambers, Moore, McEvoy, & Levin, 1996).

If psychotic symptoms can be correlated with poor insight, then reducing those symptoms in conjunction with the use of methods to increase insight may decrease relapse rates and re-hospitalizations (Schwartz, 1998b). The degree to which an individual with Schizophrenia acknowledges that he or she has a serious mental illness and needs treatment (insight) has consistently been found to predict how readily that individual will seek, or at least cooperate with treatment. Individuals with low levels of
insight, whether measured at discharge from a hospitalization or in an outpatient setting, are less likely to comply with treatment and more likely to require hospitalization during follow-up care (McEvoy, 2004).

While there has been much research devoted to the area of poor adherence, to date, no one single factor has been consistently identified as the primary cause of poor adherence. Several categories of risk factors have been repeatedly associated with poor adherence: higher levels of psychotic symptoms, poor awareness of symptoms and illness, medication issues (complexity of regimen and side effects), substance abuse, poor treatment alliance, and expectations/attitudes of support persons (Fenton et al., 1997).

Up to 55% of individuals with chronic psychotic disorders have significant difficulties adhering to treatment recommendations (Fenton et al., 1997). This has significant health implications, as poor treatment adherence is associated with increased symptomatology, relapse and hospitalization, and sustained functional impairment (Fenton et al.). Many studies have established a relationship between impaired insight and noncompliance (Amador & Strauss, 1993; Kemp & David, 1996a). In a study by Kamali et al. (2006), results showed that reduced insight is the best predictor of non-adherence in clients diagnosed with Schizophrenia. Those individuals, who deny their illness or need for treatment, are significantly more likely to be among the group who non-comply. Thus, decreased insight predicts poorer treatment compliance and prognosis (David, 1998; McEvoy, 1998, Schwartz, 1998c).

Insight is one of several factors that determine medication compliance. Noncompliance with prescribed medication is a major issue confronting the mental health profession. In a disorder, such as Schizophrenia, where noncompliance will lead to
relapse and frequent hospitalizations, the cost of noncompliance to both the individual and society is quite high. Failure to comply with prescribed medication is the most common reason for hospital readmission in individuals diagnosed with chronic Schizophrenia (Caton, 1984). Smith et al. (1999a) found that participants, who were more aware of their mental illness and of the benefits of taking medication, were more likely to be compliant with taking their prescribed medication.

MacPherson, Jerrom, and Hughes (1996) conducted a study which aimed to assess insight and compliance in 64 outpatients with Schizophrenia, of whom had “actively refused” antipsychotic treatment over the preceding 2 weeks. These individuals who “actively refused” treatment had significantly lower insight scores than those who actively participated in treatment. These studies suggest that insight and medication compliance are closely correlated, even if other factors confound the relationship.

Although appropriate pharmacotherapy has been demonstrated to be effective for treating acute symptoms and preventing severe relapses, it has fewer efficacies in alleviating deficits in psychological, neurocognitive, and social areas (Penn & Mueser, 1996). In recent years, studies have investigated the relationship between insight and psychosocial adjustment in Schizophrenia. Some studies have found relationships between impaired insight and lower scores on areas of interpersonal relatedness and basic interpersonal skills, poorer social behavior outcome, lower social functioning, and social skills (Amador et al., 1994; Lysaker et al., 1998; Smith et al., 1999b).

In a study by Schwartz et al. (1997), results showed that greater insight was significantly related to both higher global and specific functioning after long-term treatment. Furthermore, results suggest that poor insight is related to “reduced
psychosocial functioning before and after treatment, less compliance with medication and
treatment regimens, and impediments to the treatment process” (p. 287). In terms of
aftercare effects, findings show that good insight in clients correlates with superior post-
hospital adjustment (Roback & Abramowitz, 1979) and positive post-discharge outcome
(Soskis & Bowers, 1969).

Discrepancies in the literature are also evident in the area of insight and
psychosocial adjustment. In a study by Simon, Berger, Giacomini, Ferrero, and Mohr
(2004), researchers measured the relationship between psychosocial adjustments in
clients with a diagnosis of Schizophrenia. Findings showed no relationship between
measures of psychosocial adjustment and insight. However, a self-rated measure of
psychosocial adjustment was partially related to insight. Insight into illness is a primary
factor related to good versus poor outcome in schizophrenia. The relationship between
insight and outcome in clients with psychotic disorders is an important area of inquiry,
due to its prognostic and treatment implications (Amador & Strauss, 1993). Various
studies have been conducted on the relationship between insight and treatment outcome.
The findings of these studies have shown inconsistent results, largely due to differences
in measurement techniques and differences in definitions concerning the phenomenon of
insight itself. However, a general consensus seems to exist where a greater degree of
insight correlates with more favorable outcomes (Amador & Strauss, 1993).

Several empirical studies attempted to answer the question of whether increased
insight into illness relates to greater treatment gains, primarily because most theorists
believe that insight is a prerequisite to positive outcomes. In a study by McEvoy, Freter,
Everett, and Geller (1989c), researchers assessed insight and the aftercare environment to
measure external influences and clinical outcomes in clients with schizophrenia. Results supported previous findings that degree of insight is related to outcome. Clients in this study with better insight, were less likely to be readmitted to the hospital, were more compliant with treatment, and generally demonstrated better outcomes.

In another study examining outcomes, Kemp and David’s (1996b) findings indicated that insight and outcome improved in tandem with compliance. Similar results were found in yet another study by Lecompte and Pelc (1996) that tested the efficacy of an individual program for treating noncompliance with medication. As the DSM-IV states, “Lack of insight is common and may be one of the best predictors of poor outcome, perhaps because it predisposes the individual to noncompliance with treatment” (APA, p. 279).

Most of the literature base and empirical research has focused on the relationship between insight and several variables as described above, while there has been a less concentrated research on insight and level of care. The vast majority of the research regarding insight and level of care has been centered around insight and hospitalization and post-hospitalization. Results of the research in this area supports the notion that clients who are hospitalized have a lesser degree of insight at the time of admission. For example, in a study by Weiler, Fleisher, and McArthur-Campbell (2000), these authors found that the frequency of poor insight in Schizophrenia was high (50.6%) upon admission to the hospital. Furthermore, these authors found the frequency of lack of insight decreased upon discharge in these same individuals. Results from yet another study by Kemp and Lambert (1995) showed similar results for clients with psychotic disorders and degree of insight at admission to the hospital and at discharge. These
studies support the notion that the more restrictive the level of care placement is, the less insight that a client will exhibit.

Statement of the Problem and Need for the Study

Although a literature review has revealed that research of insight and its relationship to different levels of care has increased, the vast majority of previous research in this area has primarily focused on level of insight and its relationship to hospitalization and post-hospitalization. To date, there has been no research comparing insight to different levels of care (outpatient, hospitalization, and residential). There is also no current research to examine the construct of insight as a screening measure to determine level of care. If research on insight could better predict the level of care that a client may need, this would help practitioners in the application of more appropriate prevention and intervention strategies. This insight may also lead to fewer inpatient admissions as practitioners could apply the appropriate interventions before a client needs placement in a more restrictive level of care (i.e., hospitalization). In addition, this would reduce the amount of treatment dollars spent in placing clients in an inappropriate level of care, as well as ensuring that clients are placed in the least restrictive environment.

Even though the amount of literature and research surrounding insight and different levels of care has flourished, there have been several limitations to the research. One of those limitations has been the lack of a consistent definition of insight. The earliest researchers used vague definitions of insight such as verbal recognition by the client of existing psychological difficulties. Clients were then categorized as having full insight, partial insight, or no insight (Eskey, 1958). These methods were criticized for their lack of reliability and validity. Other past research defined insight in
unidimensional terms and failed to define insight as a complex, multidimensional construct, which includes more than an awareness that one has an illness. While the characteristic of having a mental disorder is an important characteristic of insight, it has been suggested that insight is not simply present or absent, but appears to be continuous and multidimensional (Amador & David, 1998). In more recent studies, there has been a gradual movement toward the conceptualization of insight in terms of more than one dimension (i.e., multidimensional). The validity of comparisons of findings among studies which correlate insight with treatment outcomes and demographic variables is limited because of lack of agreement on the conceptualization and definition of insight (Markova & Berrios, 1995; Schwartz, 1998c).

Similarly, it has been difficult to generalize from the results of various studies since many studies did not use reliable and valid measures of insight. Although many recent investigations have proposed that insight is a multidimensional phenomenon, many existing assessment methods continue to treat awareness as a unitary construct. Thus, most past and current assessment tools fail to address the complexities and dimensional (rather than categorical) nature of the phenomenon (Schwartz, 1998a). A recent literature review revealed that even current research on the measurement of insight has failed to measure insight in a multidimensional manner. For example, Lysaker and Bell (1994) rated insight and judgment of persons with Schizophrenia using a single item on the Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein, & Opler, 1987). This scale, along with several other scales used to measure insight, measures insight in a unitary fashion and therefore employs a narrow definition of insight. Although significant progress in this area has been made in the past decade, the problem still exists.
Researchers must employ precise terminology and methodology if the field is to progress further. Much of the literature has been dominated by studies that often lack standardization with respect to research design and measurement. Through nonspecificity and inconsistency in using standardized measures, a substantial portion of studies published have yielded results that have been difficult to interpret and/or compare to other studies. Many published studies have even yielded contrary results. More often than not, such divergent results are because of differences between measures used in studies that have not been clarified. This impedes progress by causing confusion and erroneous claims of “failure to replicate” (Amador & Kronengold, 2004). One interpretation of the literature to date suggests focusing on different aspects of insight and use of different methods accounts for inconsistent results across studies.

Another limitation noted by Schwartz et al. (2000) is the use of small samples in research studies. In a comprehensive literature review of all articles related to insight and psychosis between the years of 1990 and 1999, 32 empirical studies were conducted. Only six of those studies utilized sample populations in excess of 100 participants. The average number of participants in the remaining 26 articles was approximately 54. If advanced statistical analyses were used, sufficient power to find significant results would be attained. Sample studies in research with persons with Schizophrenia are typically small and not representative (Baier et al., 1998). Small sample size can reduce statistical power and limit the external validity of results. Thus, small sample sizes decrease extending significant findings to the general population. In addition to low sample size, other statistical problems noted in past research include inappropriate use of parametric statistical methods and failure to correct level of significance when conducting many
statistical tests. Parametric tests are often used in research when they are unwarranted and may give misleading results. For example, in a study by Peralta and Cuesta (1994), a large number of correlations used \( p \leq .01 \), but should have used Bonferroni correction. In addition, these researchers had an adequate sample size for factor analysis.

An additional limitation found in previous studies includes the older use of diagnostic criteria for diagnosing an individual with a psychotic disorder, even when more revised diagnostic criteria were available. This limitation calls into question the more narrowly defined criteria and may have impacted individuals, who would have been eligible to participate in the study based on meeting/not meeting diagnostic criteria. Since the DSM and its diagnostic criteria have evolved over the years, it would be important that sample subject inclusion reflected the most revised diagnostic criteria available to researchers. Not to mention that more recent diagnostic criteria (DSM-IV and DSM-IV-TR) have been updated to include insight as a unique characteristic in psychotic disorders and a manifestation of the illness itself rather than a coping strategy (APA, 2000).

A final limitation of recent research on insight is failure to link basic research findings with theory and practice. While research gives us empirical validation of what approaches and interventions may have efficacy, linking it to theory and practice is what brings about positive outcomes for clients suffering from psychotic disorders. Perhaps, the next step for research focused on insight in psychotic disorders is to address the practical implications of empirical results. If more information was known about insight and different levels of care, this could help clinicians use insight as a screening measure for placement in the most appropriate level of care. This would aid clinicians in
developing techniques to increase insight and possibly prevent hospitalization. In addition, clinicians could use insight as a potential screening measure to determine level of care placement, ultimately reducing the amount of money spent on an inappropriate level of care placement.

Purpose of the Study

The purpose of this study was to investigate how insight among psychotic clients impacts level of care. Specifically, the researcher studied whether insight among psychotic clients differed in clients in outpatient treatment versus inpatient treatment, and whether degree of insight related to a current need for inpatient admission. This researcher gathered data on outpatient and inpatient clients, and use of standardized instruments to measure insight and compare insight among treatment groups. Results of research findings relating level of insight and level of care may lead to the following implications:

- The construct of insight may be utilized as a screening measure to aid clinicians in level of care placement for clients with psychotic disorders.
- Clinicians could utilize the construct of insight to apply appropriate prevention and intervention strategies before clients experience a relapse and require a more restrictive level of care.
- Awareness of the need to assess insight will increase among counselor educators, professional counselors, and counselor-trainees.
- Additional research on insight and level of care placement may be prompted to add to the literature base and enhance clinical practice.
• Client outcomes and quality of life may be improved due to more appropriate prevention and treatment strategies, reducing clients need for more restrictive placement.

Research Questions

This study attempted to answer the following questions:

• Are there significant differences in psychotic clients’ degree of insight according to their current level of care (i.e., inpatient versus outpatient treatment settings)?

• Do psychotic clients’ degree of insight reliably predict current need for an inpatient admission?

Definition of Terms

The most frequently used terms of this study will be defined within this section. These words and phrases will help provide a better understanding of terms used in this research study.

Anosognosia: A term applied to clients who are rendered unable to be aware of their illness, signs, and symptoms as a result of certain neurocognitive disorders resulting directly from a brain injury such as a stroke (Lele & Joglekar, 1998).

Diagnosis: The act of identifying a mental disorder, as defined by the DSM and categorized the signs and symptoms into an identifiable construct.

Diagnostic and Statistical Manual of Mental Disorders (DSM): A book published by the American Psychiatric Association that classifies all psychological disorders according to specific criteria. This book outlines a way of discussing disorders amongst various mental health professionals (APA, 2000).
Global Assessment of Functioning (GAF): This is a scale that helps clinicians track the clinical progress of individuals in global terms. It is rated with respect to psychological, social, and occupational functioning (APA, 2000).

Inpatient: This is one 24-hour level of care considered to be most restrictive in which clients are in a hospital setting on either a voluntary or involuntary basis in order to obtain treatment. Clients that are in this type of setting usually need more intensive treatment and monitoring.

Insight: This refers to an individual’s awareness of their mental disorder. In this study insight will include awareness of having a mental disorder (Amador & Strauss, 1993).

Level of Care: This defines differing levels of care in which mental health treatment is provided. This includes least and most restrictive levels of care.

Mental Health Professional: A broad term used for a professional, who is trained to understand human behavior and emotions. Mental health professionals are able to diagnose and treat mental disorders. Examples of mental health professionals include psychiatrists, psychologists, counselors, and social workers.

Outpatient: This is a level of care considered to be the least restrictive in which clients receive treatment on an outpatient basis and continues to reside in their community setting.

Psychosocial Functioning: A psychosocial of environmental problems that may negatively or positively impacts an individual’s ability to function in society (i.e., life changing event, social supports, occupation, education, economic, access to health care) (APA, 2000).
Psychotic Disorders: A category of mental disorders, listed in the DSM-IV TR (APA, 2000) that includes the presence of delusions and hallucinations.

Schizophrenia: A subgroup of psychotic disorders that includes the presence of positive symptoms: delusions and hallucinations and negative symptoms: restrictions in the range and intensity of emotional expression, fluency and productivity of thought and speech, and behavior (APA, 2000).

Symptoms: An indication, sign, or indicator of diagnoses identified in the DSM.

Treatment Compliance: This refers to an individual’s ability, or lack of, to engage in various sorts of biopsychosocial treatment.

Treatment Settings: This refers to different types of settings including outpatient, inpatient, residential, or aftercare, where an individual receives treatment.

Overview of the Remainder of the Study

Chapter II includes a thorough review of the literature related to insight and level of care among psychotic clients including a description of how awareness of illness impacts clients’ treatment setting. This review includes a comparison and critique of related research conducted by mental health professionals. Chapter III describes the methodology of this study including the general research design, null and directional hypotheses, participants, instruments, and data analysis. Chapter IV provides the results of statistical analyses used in the study as well descriptive and inferential statistics. Lastly, Chapter V includes a conclusion and summary of the statistical results found, a comparison of these results to those previous studies in the area, and a discussion of results related to theory. Implications for future research as well as practice are presented.
CHAPTER II
REVIEW OF THE RELATED LITERATURE

Chapter II describes literature relevant to insight and psychosis, and insight and level of care among psychotic clients. Specifically, this chapter examines literature and research pertaining to the relationship between degree of insight into illness and level of care among client with psychotic disorders. The writer offers a critique of pertinent empirical research in this area, as well as a general rationale for the approach that it used to improve upon previous studies in this area.

Review of Empirical Literature Related to Insight and Level of Care

As the climate of the mental health care system in the United States places increasing emphasis on cost effectiveness and treatment efficacy, (based on the writer’s professional experience) there is a growing need to place clients in the least restrictive and most appropriate level of care. This is especially relevant for those mental illnesses, that are costly not only to individuals and families, but to society as well. One of these categories of mental illnesses is psychotic disorders. Historically, individuals diagnosed with psychotic disorders were hospitalized or institutionalized for months or even years. However, with the movement toward deinstitutionalization, more and more individuals with psychotic disorders are residing in community settings and being treated in an outpatient level of care (American Psychiatric Association [APA], 1997). One of the determinants resulting in a more restrictive level of care with more invasive treatment
regimens (e.g., hospitalization and other in-patient settings) includes an exacerbation of psychotic symptoms (APA, 1997). For example, heightened psychotic symptoms may result in reduced ability to care for oneself, bizarre or disorganized behaviors, or threat of harm to self or others (APA, 2000). One variable that has been shown to reliably predict severity of psychotic symptoms and global functioning ability is degree of insight into one’s illness. Better insight into the nature of one’s illness, the consequences of one’s symptoms, and the need for (and understanding of) treatment options often results in less extreme symptoms, better functioning, and overall better prognosis (Schwartz, 1998c). Therefore, researchers have recently begun to investigate insight as one of the factors impacting level of care placement among psychotic clients. The following empirical research examined insight and its relationship to different levels of care, described in order from most restrictive to least restrictive treatment environments.

Insight and Inpatient Admissions Among Psychotic Clients

Hospitalization is one of the most important decisions in client care. This is attributed to the complexity and intensity of inpatient treatment, and the separation of the client from their family and community. Consequently, there have been many attempts at identifying factors related to or predicting the need for inpatient versus outpatient care (Ahn, Mezzich, Ahn, & Fabrega, 1994). Greater personal disability and its association with an increased likelihood of hospital admissions probably reflects the greater need for inpatient care among persons with low competence in daily living skills, few or no career or life interests, poor self-care skills, and generally low levels of global functioning (Carr et al., 2003). This may be especially true among clients diagnosed with a psychotic disorder. For example, in a study by Ahn et al. (1994), the researchers aimed to
systematically assess the relationship between elements of a comprehensive psychiatric diagnostic formulation and psychotic hospitalization decisions. Results showed that clients with psychotic disorders tended to frequently be admitted to inpatient care (76%) and had the strongest positive correlation with inpatient care among all psychiatric diagnoses. Inpatient clients had a higher number of diagnostic complexities than outpatient clients. The diagnostic variables most strongly associated with hospitalization were lower Global Assessment of Functioning scale scores (highest level of adaptive functioning in the past year). In addition, results showed that higher psychosocial stressor severity (DSM Axis IV) favored outpatient care in psychotic clients. The authors go on to explain that clients, who show greater impairment in functioning as well as multiple diagnoses, may be cogently seen as more severely ill and consequently as requiring more intensive care. However, it is important to know more about how degree of insight in particular affects psychotic clients’ functioning and ultimately level of care (Schwartz, 1998b), a relationship not studied by Ahn et al. (1994).

Relapse and frequent readmissions are common among individuals diagnosed with Schizophrenia (Schwartz, 1998a). Clients, with poor insight into illness, may have higher relapse rates as well as display an increased number of hospital readmissions (Schwartz, 1998b). Factors associated with multiple readmissions include the number of previous admissions, longer inpatient stay, and a diagnosis of psychosis (Jakubasch, Waldvogel, & Wurmle, 1993). In a study conducted by Draman et al. (2005), researchers aimed to identify the risk factors of readmission in less than 6 months from previous admission among individuals diagnosed with Schizophrenia. Results showed that insight was one among other variables/risk factors for repeated admissions. In a previous study,
McEvoy, Apperson, Appelbaum and Ortlip (1989c) also found similar findings in that lack of insight is associated with re-hospitalization.

In a study by Kelly et al. (2004), the researchers attempted to identify predictors of involuntary admissions in first episode Schizophrenia. The sample consisted of 78 clients diagnosed by the DSM-III-R with Schizophrenia. Of the clients admitted, 17 (22%) were on an involuntary basis and 61 (78%) were admitted on a voluntary basis. A single item on the Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987) was used to measure insight. Results showed that lack of insight predicted involuntary admission status in first episode Schizophrenia.

McEvoy, Appelbaum, Apperson, Geller, and Freter (1989b) examined the relationship between insight and psychopathology in a group of clients who met the DSM-III criteria for Schizophrenia or Schizoaffective Disorder. The 52 participants in the sample were judged to be in an acute psychotic episode related to medication noncompliance. Of the 52 participants, 28 were admitted on a voluntary basis and 24 were involuntarily committed. Findings strongly supported clinical intuition in that voluntary and involuntary clients differed in degree of insight into their illness and need for treatment. Clients, who were involuntarily committed, displayed significantly lower insight ratings on the Insight and Treatment Attitudes Questionnaire (ITAQ; McEvoy et al., 1989a) at the time of admission, relative to voluntarily admitted clients. The authors report that involuntarily committed clients required coercive hospitalization because they failed to recognize their need for care. Furthermore, involuntarily hospitalized clients’ deficits in insight appeared more intractable. While levels of psychopathology
diminished for both voluntary and involuntary clients during hospitalization, only voluntary clients showed an increase in insight ratings over the hospitalization period.

Weiler et al. (2000) assessed changes in insight during the course of short-term inpatient treatment across diagnostic groups to examine if changes in insight are related to changes in symptomatology. The sample consisted of 187 clients diagnosed according to DSM-III-R diagnostic criteria, such as Schizophrenia, Major Depressive Disorder, Bipolar Disorder, ‘other psychosis,’ or Schizoaffective Disorder, who were hospitalized on an involuntary basis. The ITAQ was used to measure insight (McEvoy et al., 1989a). A one-way analysis of variance was performed to assess differences in insight at admission and discharge across diagnostic groups. The frequency of poor insight in Schizophrenia (50.6 %) and ‘other psychosis’ (73.7%) upon admission was very high. Upon discharge, the frequency of lack of insight had decreased in Schizophrenia (37%) and ‘other psychosis’ (42.1%). Findings from this study revealed a strong relationship between insight deficits and initial involuntary commitment status. Poor insight could be interpreted as less problematic or common among clients entering outpatient treatment regimens (i.e., those being discharged from the inpatient setting).

Schwartz et al. (1997) investigated whether insight affected specific measures of treatment outcomes in Schizophrenia among clients requiring long term residential treatment. The sample consisted of 23 chronically psychotic clients, who were randomly selected from an inpatient residential treatment program. Clients were diagnosed according to DSM-IV criteria with a diagnosis of Schizophrenia. The study took place over the course of one year and clients were administered various measures related to functioning (e.g., stress management skills, medication compliance, interpersonal skills).
at admission and at the end of the year-long study. Degree of insight was measured by the Scale to Assess Unawareness of Mental Disorder (SUMD; Amador & Strauss, 1993). Findings showed that clients with good insight evidenced better improvement after long-term inpatient treatment than clients with poorer insight. That is, greater insight was shown to be significantly related to both higher global and specific functioning after long-term treatment.

In another study by Kemp and Lambert (1995), the researchers examined the relationship between negative, positive, and affective symptoms, and insight in a cross-sectional analysis at different points in the treatment process. The sample consisted of 29 clients, who were diagnosed with Schizophrenia according to DSM-III-R criteria, and who were admitted to the hospital in an acute status. Clients were administered measures of insight and psychopathology at admission and at discharge between 3 and 6 weeks later. A modified version of the SUMD (Amador & Strauss, 1993) was used to measure insight. Statistical analyses were conducted using paired t-tests and a one-way analysis of variance. Results indicated improvements in psychopathology and gains in insight over the hospitalization period. Average scores on the insight subscales were poor at admission. Clients manifested only modest insight at discharge with ‘awareness’ of illness faring better than ‘attribution’ (or cause) or illness at both assessment periods. However, these results provide some additional support for the contention that more acute inpatient clients have poorer insight than those ready for discharge (i.e., those who will soon be outpatient clients).

Cernovsky, Landmark, Merskey, and Husni (2004) did an exploratory study, examining lack of insight and its association with more psychopathology and a more
chronic course of illness. The researchers studied 111 clients, diagnosed with Schizophrenia according to DSM-III criteria. Participants were admitted to an inpatient hospital in Canada. Insight was measured by researcher-generated questions used to assess the presence of insight/awareness of being psychiatrically ill -- whether they thought anything was wrong with mental functioning when hospitalized, why they were hospitalized, was the hospitalization justified, and why psychiatric medication was used for them. Insight was coded as a dichotomous variable (present = 2, absent = 1.) Clients were also administered Landmark’s clinical checklist (Cernovsky & Landmark, 1994; Landmark, 1982) to assess symptomatology. These ratings were based on medical records and interviews with psychiatrists. Findings showed an apparent lack of awareness in 58.6% (65 of 111) clients either during initial interviews, within last 6 months, or both. Almost all clients displayed lack of insight at some point in the past (97.3%, or 108 of 111 clients). These data confirm that lack of awareness of being ill is common in inpatient clients diagnosed with Schizophrenia, and is highly likely to be present at some other point in the course of the illness.

Insight and Post-Hospitalization Discharge Status Among Psychotic Clients

In a study by Smith et al. (2003), the researchers aimed to assess changes in symptom awareness in a sample of 50 clients diagnosed with Schizophrenia or Schizoaffective Disorder according to the DSM-IV criteria. Participants were followed over a 6-month period after inpatient treatment for an acute symptom exacerbation. Clients were recruited upon admission to an outpatient treatment program after 30 days of discharge from the hospital. Measures of insight, symptoms, and executive functioning were given at baseline and at 6 months. Insight was measured using the
SUMD (Amador & Strauss, 1993). Results demonstrated that two of the four variables assessed in the study showed modest, nonsignificant improvements over time, indicating that insight may not change appreciably in the early stages of outpatient treatment in individuals with Schizophrenia. These findings are consistent with the other results (Smith et al., 1998; Weiler et al., 2000) which suggests that improvement in insight over the course of acute inpatient treatment does occur, but that there is a lack of further substantial improvement in the outpatient phases of treatment (Cuesta, Peralta, & Zarzuela, 2000; Fennig et al., 1996).

Fennig et al. (1996) examined the “prevalence, six-month temporal stability and demographic correlates of insight in a diagnostically heterogeneous sample of psychotic clients during their first hospitalization” (p. 258). The sample consisted of 189 clients diagnosed with Schizophrenia (n = 86), psychotic Bipolar Disorder (n = 52), psychotic Depression (n = 35), and ‘other psychoses’ (n = 16). Participants were diagnosed according to DSM-III criteria. Interviews and measures to assess insight and psychopathology were completed at baseline (in the hospital) and at 6 months (in the community). Results showed that at baseline, impairment of insight (as measured by the modified Hamilton Depression Scale (Hamilton, 1960), was strongly associated with having a diagnosis listed above. Very few clients with a diagnosis of Schizophrenia, Bipolar, and ‘other psychoses’ had insight into their illness. At the 6-month follow-up, a substantial number of the clients diagnosed with Schizophrenia, ‘other psychosis,’ and Delusional Disorder lacked insight. The authors report that lack of insight appeared to be associated with the presence of psychosis at the height of the episode, but is differently distributed by diagnosis later in the 6-month course. In the subgroup of clients with
Schizophrenia whose insight ratings declined at the 6-month follow-up, the decrease in insight co-occurred with the worsening of psychosis in a majority of cases.

In another longitudinal study by Cuesta et al. (2000), the authors investigated whether insight changes with time, and how it relates to clients’ psychopathology. The sample consisted of 75 consecutively admitted clients, who met criteria for the following DSM-IV diagnoses: Schizophrenia (n = 37), Affective Disorder with psychotic symptoms (n = 27), or Schizoaffective Disorder (n = 11). Clients were evaluated at two different points after a remission of an acute episode. Clients were in a phase of clinical stabilization after inpatient discharge ranging from 6 months to 2 years. Clients were administered a scale to assess psychopathology at baseline and follow-up, and were given three instruments to measure insight (SUMD, ITAQ, and 3 insight items from the Manual for Assessment and Documentation in Psychopathology). Statistical analyses included repeated measures of multivariate analysis of variance, Pearson correlation coefficients, and multiple regression. Results showed, at baseline assessment, that a large proportion of clients had a moderate to severe lack of insight depending on which insight measure was used (i.e., between 49% and 66%). At follow-up assessment, between 29% and 49% of these clients continued to have fair to poor insight. These results indicate that level of insight into illness did not significantly improve over time in clients suffering from functional psychoses. Findings are consistent with other results that show lack of insight is a prevalent feature of functional psychoses in cross sectional studies (Kemp & Lambert, 1995; McEvoy et al., 1989c).

In another longitudinal study by Smith et al. (1998), these researchers investigated ratings of symptoms and insight at baseline and follow-up (i.e., 86.7 days for outpatient
and 20.4 days for inpatients). The sample included 33 individuals diagnosed according to DSM-IV criteria with Schizophrenia or Schizoaffective Disorder. All clients had recently experienced an acute psychotic exacerbation requiring hospitalization. Study participants included 17 (52%) who were recruited upon discharge from the hospital and 16 (48%) who were hospitalized throughout the study. Both cross-sectional and longitudinal analyses showed significant but only moderate associations between insight and symptoms of depression and disorganization. Higher levels of depression were associated with the improved awareness and attribution as measured by the SUMD (Amador & Strauss, 1993), whereas higher levels of disorganized symptoms were associated with deficits in awareness and attribution of one’s illness. These findings suggest that insight deficits in Schizophrenia vary depending on factors such as course and phase of illness.

Novac-Grubic and Tavcar (2002) studied compliance with treatment in first-episode clients with psychotic disorders in order to identify predictors of noncompliance. The sample included 56 consecutively admitted male clients diagnosed according to International Classification of Diseases, 10th edition (ICD-10; WHO, 1993) with Schizophrenia, Schizophreniform Disorder, and Schizoaffective Disorder. Procedures for recruiting was random for participants discharged from the hospital after an exacerbation of psychotic symptoms and were included in the one-year follow up study. Insight was measured by the PANSS (Kay et al., 1987). Results showed that three variables were related to noncompliance: diagnosis of Schizophrenia, poor insight at discharge, and severity of positive symptoms at admission.
Insight and Outpatient Treatment Status Among Psychotic Clients

In one of the earlier studies examining insight in an outpatient setting, Heinrichs, Cohen, and Carpenter (1985) studied early insight in a group of 39 psychotic clients who met the Research Diagnostic Criteria for Schizophrenia (n = 33) or Schizoaffective Disorder (n = 6). The researchers hypothesized that early insight would predict a successful resolution of relapse on an outpatient basis without the need for rehospitalization. Insight and relapse were measured by clinical judgment, interviews, and record reviews. Findings supported the hypothesis, in that a greater percentage of participants who demonstrated early insight required less frequent hospitalizations. A greater percentage of those participants found to be uninsightful required hospitalization. Early insight appears to represent an awareness of increased symptoms that should motivate individuals to seek and cooperate with treatment interventions during the critical phase of relapse. These findings suggest that early insight serves an instrumental role in the prevention of decompensation.

Coursey, Keller, and Farrell (1995) conducted a study in an outpatient setting using 191 randomly selected clients with serious mental illnesses (of whom at least 38% had a diagnosis of Schizophrenia). Results showed that only 8% of clients in psychosocial rehabilitation centers believed that they had a mental disorder, and only 25% believed their illness was caused by a combination of psychological problems and a brain disease. Sixty percent believed a combination of medication and talk therapy was helpful. These results support the notion that even clients in an outpatient setting may not be fully insightful.
In a study by Dickerson, Boronow, Ringel, and Parente (1997), the researchers examined the prevalence of insight among outpatients diagnosed according to DSM-III-R criteria with Schizophrenia or Schizoaffective Disorder. They investigated the relationship between lack of insight and other variables. The sample consisted of 54 clients in an outpatient program in a metropolitan area, all rated by their psychiatrist as stable over the previous month. These individuals were receiving a combination of outpatient services from counseling, community rehabilitation day programs. Insight was measured by the PANNS (Kay et al., 1987). Participants showed moderate levels of impairment with mean score of 48 +/- 12 on the Global Assessment of Functioning scale. Results demonstrated that in general insight into illness was at least moderately impaired (49.5%), and 25% of participants had severe insight deficits. Furthermore, clients who received professional residential supervision had more insight deficits than those who did not receive those services. Because this sample was drawn exclusively from outpatients, results highlight the extent to which insight deficits exist among stable clients in an outpatient level of care. Researchers concluded that lack of insight is a prevalent clinical feature of Schizophrenia and is not merely a reflection of overall symptom severity. However, those clients who needed more invasive outpatient treatment did in general manifest poorer insight.

Kim, Sakamoto, Kamo, Sakamura, and Miyaoka (1997) attempted to predict which aspects of insight are closely bound to the psychopathology of Schizophrenia, and which are influenced by other factors and are therefore more similar to a psychological “state.” Their sample consisted of 63 clients diagnosed with Schizophrenia according to the ICD-10 (WHO, 1993), recruited from inpatient (n = 18) and outpatient (n = 45)
settings in Japan. Insight was measured by the Scale to Assess the Components of Insight (SAI; David, 1990b), a three-dimensional scale which dealt with treatment compliance, awareness of the need for treatment of illness, and awareness of psychotic experience. Clinical factors that may have influenced insight were grouped into objective psychopathology, subjective experience, and treatment settings. Results showed that awareness of the need for treatment was significantly higher in the outpatient group versus the inpatient group and was not correlated with any other variables. These authors noted that most studies reporting poor insight in Schizophrenia, sampled clients, with acute Schizophrenia, whose symptoms may have impaired their awareness of illness. On the contrary, reports about intact insight in Schizophrenia tend to come from chronic samples.

Carroll et al. (1999) examined the relationship between insight and other variables, as well as the relationship between longitudinal changes in insight and changes in symptoms. The sample consisted of 100 clients with a DSM-III-R diagnosis of Schizophrenia ready for discharge from inpatient or day patient care. Clients were administered baseline assessments to measure insight, psychopathology, and depression. A random sample was assigned to a control group and an intervention group designed to improve insight. Results showed that at baseline, better insight (as measured by ITAQ (McEvoy et al., 1989a), was significantly correlated with lower mood and fewer positive psychotic symptoms. Follow-up assessments showed that improvement in insight was related to worsening of mood, but not to change in positive symptoms. Results suggest that poor insight partially results from the psychotic disease process itself.
In another study, Yen, Yen, Chen, and Chung (2002) explored the predictive value of insight ratings related to suicide, violence, hospitalizations, and social adjustment for 74 outpatient clients diagnosed with Schizophrenia according to DSM-IV criteria. Subjects were given a baseline measure to assess insight and other variables and were then reassessed at a one-year follow up to determine the predictive value of initial insight ratings. Insight into treatment was measured by the SAI (David, 1990b) and the SAI-E (Kemp & David, 1996b). Better insight into treatment needs was associated with fewer hospitalizations and better social adjustment, but insight into mental illness or psychotic experience was not.

In a final study found on insight among outpatient psychotic clients, Mintz, Addington, and Addington (2004) examined the association between insight and positive symptoms, negative symptoms, and cognition to determine if insight improved after one-year of treatment. The sample consisted of 180 clients who were experiencing their first episode of psychosis and had not received more than 3 months of previous treatment. All clients met criteria for Schizophrenia according to DSM-IV criteria. Insight was assessed by using one insight-related item on the PANSS (Kay et al., 1987) upon admission and after 3, 6, and 12 months. Results showed that 64% of first-episode clients demonstrated good insight at the initial assessment, and 79% at the one-year follow up. These results are contrary to previous similar studies that reported less than half of their sample demonstrated good insight (e.g., Fennig et al., 1996).

With increasing movement toward deinstitutionalization of psychotic clients, the focus of treatment has shifted to outpatient settings. An important goal of outpatient treatment is to prevent or reduce rehospitalization rates when possible, but also to treat
those relapses that do occur before psychosis reaches such severity that rehospitalization is inevitable (APA, 1997). This strategy would involve intervening as early as possible as an individual begins to decompensate. Early intervention would be greatly facilitated by the individual’s insight to recognize the early phase of relapse from his or her illness and to seek treatment (Heinrichs et al., 1985).

In summary, the majority of research on insight and inpatient admissions among psychotic clients generally showed similar results in that clients in this treatment setting demonstrated poorer insight at baseline and often had multiple readmissions. Results across studies identified poor insight as a risk factor for hospitalization. Results of research on insight and post-hospitalization discharge status among psychotic clients generally showed that only modest improvements were made with regard to awareness of illness. Furthermore, findings described lack of insight as a prevalent feature of functional psychosis even in cross sectional studies. Insight varied depending on the course and phase of illness among the participants in the studies. Although scanty, results of research on insight and outpatient treatment settings among psychotic clients also showed that insight deficits exist even among stable clients in an outpatient setting; however, the more chronic the illness, the worse insight seems to be. Findings suggest that early insight serves as an instrumental role in the prevention of psychological decompensation and possible hospitalization.

Critique of Research on Insight and Level of Care Among Psychotic Clients

Although a great deal of research has been conducted in the past 15 years on insight and psychotic disorders, some of which has focused on different levels of care, several important limitations have been noted among these studies. A better
understanding of these limitations can aid in furthering research in this vital area, in addition to expanding theory and clinical practice. Methodological weaknesses and related limitations of previous research are outlined below by synthesizing these into broad categories according to type of limitation.

Researchers must employ precise terminology and methodology in terms of instrumentation if the field is to progress further. Through nonspecificity and inconsistency in using standardized measures, a substantial portion of prior studies have yielded equivocal results and contradictory results. Often divergent results are found due to researchers not using reliable and valid measures of insight. For example, of the studies reviewed, several studies used the PANSS (Kay et al., 1987) to measure insight (e.g., Dickerson et al., 1997; Kelly et al., 2003; Mintz et al., 2004; Novak-Grubick & Tavcar, 2002). This scale only has a single item to assess insight. Because this scale consists of a very simple measure of insight, it is less reliable and lacking in construct validity as compared to other insight measures (Amador & Kronengold, 2004). Fennig et al. (1996) used a modified insight item on the Hamilton Depression Scale (Hamilton, 1969) to measure insight. This scale is similar to the PANSS, due to its single item used as a measure of insight; however, it is less reliable and lacks construct validity. Two of the studies found in this literature review (Cernovsky et al., 2004; Heinrichs et al., 1985), relied on subjective clinical observations and judgments to measure insight. In both of these studies no objective quantitative method for evaluating or categorizing responses was employed.

Therefore, it has been determined that in terms of insight measurement, these studies are lacking both in reliability and validity. Of the studies reviewed above, four
studies used the ITAQ to measure insight (Carroll et al., 1999; Cuesta et al., 2000; McEvoy et al., 1989b; Weiler et al., 2000). This scale is comprised of 11 items designed to assess clients’ recognition of illness and need for treatment. Ratings are scored by consensus using a 3-point scale but “how such scores were decided is not made clear” (Markova & Berrios, 1992). Therefore, although the ITAQ is generally viewed as a more effective instrument than others used in previous studies (Schwartz, 1998c), it has serious methodological flaws. Five of the studies reviewed above utilized the SUMD (Amador & Strauss, 1993) to measure insight (Cuesta et al., 2000; Kemp & Lambert, 1995; Schwartz et al., 1997; Smith et al., 1998; Smith et al., 2003). This instrument offers a systematized scoring method to rate responses to controlled stimuli after use of a semi-structured interview. The SUMD is currently viewed as among the most reliable and valid measures of insight in psychosis (Schwartz, 1998c); and although more researchers are using the SUMD, it has not been widely utilized over the previous 10 years. It is recommended that this instrument be used, in conjunction with the semi-structured assessment method, in order to enhance the validity of insight measurements.

A second weakness found in the literature reviewed above is the use of assessment measures, that evaluate insight as a unidimensional construct. Many researchers have proposed that insight is a multidimensional phenomenon; however, existing assessment measures of insight often score the construct on a unitary versus multidimensional scale. Ghaemi and Pope (1994) are exceedingly clear in emphasizing this point. These authors state that, “The definition and measurement of insight in various studies are not standardized so comparing studies with one another is misleading” (p. 31). Of the literature reviewed, only six utilized scales that assess insight as a
multidimensional phenomenon (Cuesta et al., 2000; Kemp & Lambert, 1995; Schwartz et al., 1997; Smith et al., 1998; Smith et al., 2003; Yen et al., 2002). These studies included the SUMD and SAI-E. The SUMD distinguishes between two dimensions of insight, awareness of illness and attribution regarding illness. In addition, the SUMD allows for the independent assessment of current and retrospective awareness of having a mental disorder, awareness of particular signs and symptoms, and the psychosocial consequences of having a mental disorder (Amador & Kronengold, 2004). Similarly, the expanded version of the SAI-E also measures insight in a multidimensional way. All the other measures of insight used in prior studies provided a measurement of insight in a unitary fashion and therefore employ a narrow definition of insight. These scales do not assess many of the psychological domains that are believed to comprise insight into illness more generally (i.e., ITAQ, SAI, PANSS, Hamilton Depression Scale, and the AMDP).

A third major methodological weakness of studies on insight and psychosis is the use of small sample sizes. Small sample size can reduce statistical power (Cohen, 1992) and can also affect generalizability of results. Of the studies reviewed above, six utilized samples of less than 50 participants (i.e., Heinricks et al., 1985; Kemp and Lambert, 1995; McEvoy et al., 1989b; Schwartz et al., 1997; Smith et al., 1998; and Smith et al., 2003). Five of the studies utilized samples of 100 or more participants, which would provide sufficient power to find significant results (i.e., Carroll et al., 1999; Cernovsky et al., 2004; Fenning et al., 1996; Mintz et al., 2004; Weiler et al., 2000).

An additional limitation found in many previous studies on insight and level of care among psychotic clients includes the use of older diagnostic criteria for diagnosing an individual with a psychotic disorder, often even when more recent diagnostic criteria
were available. More than 12 of the studies found in this literature review utilized older diagnostic criteria for mental disorders, which may have impacted participants’ eligibility for inclusion in the studies. In fact, three of these studies (i.e., Cernovsky et al., 2004; Kelly et al., 2003; Weiler et al., 2000) utilized criteria that were two or three revisions behind the most current DSM diagnostic criteria. This fact is especially significant because more recent versions of the DSM (e.g., DSM-IV versus DSM-III-R) incorporate more stringent criteria for diagnoses of Schizophrenia and Schizoaffective Disorder. Therefore, based on the diagnostic criteria used in most prior studies, it is difficult to determine if participants technically suffered from these disorders or others that often mirror similar psychotic symptoms (e.g., Bipolar Disorder with Psychotic Features).

In addition, some other limitations found in previous studies included lack of random samples. Of the articles reviewed only two identified random samples (Novak-Grubic et al., 2002; Schwartz et al., 1997). Few studies used blind raters when evaluating insight and other variables (Carroll et al., 1999; Cuesta et al., 2000; Schwartz et al., 1997). Most studies lacked a control or comparison group (Schwartz et al., 1997). Very few articles listed clinicians’ training on the instruments being used to measure variables. Lastly, most of the diagnoses and insight measurements were conducted by psychiatrists, psychologists, or what authors simply termed “researchers.” Even though professional counselors are able to diagnose mental disorders and rate clients’ degree of insight, for unknown reasons, counselors were not utilized in past studies. Therefore, additional research is warranted in which professional counselors are employed to evaluate clients’ symptoms and degree of awareness into their mental disorder.
In summary, a review of the literature has illuminated the fact that results from previous research studies on insight and level of care among psychotic clients should be interpreted with caution. While some of the findings may seem to validate clinical intuition and demonstrate face validity, results across studies have shown questionable results. As previously mentioned, this is largely due to studies focusing on different aspects and definitions of insight, use of various measures of insight with differing degrees of reliability and validity, outdated diagnostic criteria, and limited statistical power when analyzing results. While the research on insight in psychotic clients and measures to assess insight has grown substantially over the past 15 years, it is important when carrying out research to keep in mind the limitations listed above and strive to overcome them so that further research can improve upon theory and clinical practice, with the ultimate goal of improving treatment and outcomes for clients with psychotic disorders.

Rationale for the Approach

Insight in psychotic disorders has been an area of interest for researchers and clinicians alike. In the past 15 years, a plethora of research has been dedicated to the study of this phenomenon in hopes of expanding upon research and theory and improving upon clinical practice. While results of research findings have resulted in discrepancies, most researchers are in agreement that insight is a multidimensional construct and should be measured as such. Although a literature review has revealed that research on insight and its relationship to different levels of care has increased, the vast majority of previous research in this area has primarily focused on level of insight and its relationship to hospitalizations and recent post-hospitalizations. Additional research comparing insight
to different levels of care (outpatient, hospitalization, and residential treatment settings) is clearly warranted. There is also no current research examining the construct of insight as a screening measure to determine level of care. If research on insight could better predict clients’ level of care, this would help practitioners in the application of more appropriate prevention and intervention strategies. It would also help to ensure that clients be placed in the most appropriate level of care where they could receive the most optimal treatment. Finally, more methodologically sound research is needed, that is, research on insight and level of care that incorporates contemporary diagnostic criteria, valid and reliable assessment instruments, large and diverse sample populations, and diversity of evaluating clinicians (e.g., professional counselors).

This study takes into consideration the limitations of prior research in this area in order to further investigate and expand upon insight-oriented research. To reiterate, research question number one asks, “are there significant mean differences in psychotic clients’ degree of insight according to their current level of care (i.e., inpatient versus outpatient treatment settings)?” In order to answer this research question a group comparison method is employed. Specifically, data related to insight (assessed multidimensionally) in clients who have been diagnosed with psychotic disorders according to the most recent version of DSM (i.e., DSM-IV-TR) are compared according to their current level of care (inpatient versus outpatient treatment settings). Between-group mean differences in degree of insight using the SUMD are tested to determine if clients, who are in more restrictive treatment settings on average have poorer insight into their illness.
Research question number two states, “does psychotic clients’ degree of insight reliably predict current need for inpatient admission?” In order to answer this research question a non-experimental (i.e., descriptive) approach is utilized. The goal for answering this research question involves determining the relationship between two quantitative variables. That is, scores on degree of insight (measured using the SUMD; Amador & Straus, 1993) are correlated with scores on a scale used to determine current need for inpatient treatment (as measured by the Functional Assessment Rating Scale [FARS]; Ward & Dow, 1994). The dependent variable in this research design is a FARS rating of need for inpatient admission. Clinician ratings of insight serve as the independent variables. In this research design, a large sample is employed to ensure adequate statistical power, a factor often not taken into account in prior research. The scales that are utilized to measure insight are widely accepted, as well as reliable and valid. All participants have diagnoses that were made using the DSM-IV criteria.
CHAPTER III

METHODOLOGY

The purpose of this study was to investigate how insight among psychotic clients impacts level of care. Specifically, this researcher studied whether insight among psychotic clients differed in clients in outpatient treatment versus inpatient treatment, and whether degree of insight related to a current need for inpatient admission. This researcher gathered data on outpatient and inpatient clients, and use of standardized instruments to measure insight and compared insight among treatment groups. This goal was achieved by analyzing archival data from a large community mental health agency in a Southeastern state utilizing an ex post facto research design. This chapter provides an overview of the research questions, a description of the variables, and an overview of the research design for the study.

General Research Questions

1. Are there significant differences in psychotic clients’ degree of insight according to their current level of care (i.e., inpatient versus outpatient treatment settings)?

2. Do psychotic clients’ degree of insight reliably predict current need for an inpatient admission?
Null and Directional Hypotheses

Null hypothesis 1: There is no statistically significant difference in psychotic clients’ degree of insight, as measured by the Scale to Assess Unawareness of Mental Disorder (SUMD; Amador & Strauss, 1993), and client’s current level of care (inpatient versus outpatient).

Directional hypothesis 1: There is a statistically significantly lower degree of insight, as measured by the SUMD (Amador & Strauss, 1993), among psychotic inpatient clients than among outpatient clients.

Null hypothesis 2: There is no statistically significant relationship between degree of insight, as measured by the SUMD (Amador & Strauss, 1993), and current need for inpatient admission as measured by the Functional Assessment Rating Scale (FARS; Ward & Dow, 1994).

Directional hypothesis 2: There is a statistically significantly positive relationship between degree of insight, as measured by the SUMD (Amador & Strauss, 1993), and the need for inpatient admission as measured by the FARS (Ward & Dow, 1994) (i.e., as degree of insight [as measured by ratings on the SUMD] decreases, need for inpatient admission [as measured by ratings on the FARS] also increases).

Description of Independent and Dependent Variables

In order to test null hypotheses one, three quantitative dependent variables and one categorical independent variable were utilized. The dependent variable included three global insight subscales on the SUMD (Amador & Strauss, 1993). These subscales are (a) overall awareness of having a psychotic disorder; (b) awareness of the social consequences of the disorder (e.g., social withdrawal, hospitalizations, interpersonal relationship difficulties); and (c) awareness of the need for treatment (e.g., medications and counseling). The categorical independent variable included inpatient or outpatient level of care. Inpatient care is a 24-hour level of care considered to be most restrictive in which clients are in a hospital setting on either a voluntary or involuntary basis in order to obtain treatment. Outpatient care is a level of care that is considered to be least
restrictive in which clients receive treatment on an outpatient basis and reside in the community setting. Although hypothesis one has not yet been researched, based on previous research studies, it was expected that the directional hypothesis will be supported.

In order to test null hypothesis two, one quantitative dependent variable and three quantitative independent variables were utilized. The dependent variable included the rating for current need for inpatient admission using the FARS (Ward & Dow, 1994). The quantitative independent variables included three global insight subscales of the SUMD (Amador & Strauss, 1993). While hypothesis two has not been tested, it is logical that the directional hypothesis will be supported. Prior research has shown that inpatient clients usually demonstrate poorer insight than those clients in an outpatient setting.

Research Design

In this study, archival data were collected and analyzed in order to test the null and directional hypotheses. Archival (or fixed) data are data that are collected and stored on a periodic basis by a participating mental health agency. Archival data included previously documented factual information about the client’s race, sex, age, and clinical diagnosis, in addition to quantitative data related to the SUMD (Amador & Strauss, 1993) and FARS (Ward & Dow, 1994).

The research design employed in this study was ex post facto with tests of alternative hypotheses. According to Kerlinger (1973), “ex post facto research is a systematic inquiry in which the scientist does not have direct control of the independent variables because their manifestations have already occurred or because they are inherently not manipulable” (p. 379). Another distinction about ex post facto research is
that “it contains an attribute or assigned variable that can only show relationships – not causation” (Newman, Benz, Weis, & McNeil, 1997, p. 38). Even though ex post facto research findings cannot be used to infer causation, the tests of relationships can be extremely useful to researchers. Newman and Newman (1994) explain that, “one of the most effective ways of using ex post facto research is to help identify a small set of variables from a large set of variables related to the dependent variable for future experimental manipulation” (p. 124). This means that when examining relationships of two or more variables, ex post facto research is appropriate. Specifically, this study examines the relationship between insight among psychotic clients and level of care as well as whether degree of insight related to a current need for an inpatient admission. Ex post facto research with tests of alternative hypotheses are hypotheses that propose other rationales for the effect other than the one stated. These explanations are competing hypotheses to the ones the researcher is interested in verifying. Thus, the more alternative hypotheses that can be eliminated, the greater the internal validity of the research design (Newman et al., 1997).

In order to test statistical hypothesis one, the research design included a study of group differences. This design utilized three dependent variables and one categorical independent variable. This design helped to identify whether group differences in the independent variables (inpatient or outpatient treatment settings) have a significant effect on the dependent variables (three quantitative global insight subscales on the SUMD).

In order to test statistical hypothesis two, this researcher looked at how much variance in the dependent variable (rating on the FARS, that is, current need for inpatient admission) was explained by the independent variables (three global insight subscales of
SUMD). The researcher used archival data on ratings of insight scored by counselors at an inpatient facility to determine if they are associated with counselors’ decisions to admit clients into an inpatient level of care.

Data Analyses

First, descriptive statistics were obtained for all variables including ratings on the SUMD (Amador & Strauss, 1993), FARS (Ward & Dow, 1994), and participants’ demographic characteristics. Descriptive statistics included the means, standard deviations, and ranges of the independent and dependent variables. After descriptive statistics were reported for all demographic variables, inferential statistics were used to test the null and directional hypotheses. An alpha level of $p < .05$ was used to interpret results of statistical analyses.

In order to statistically test hypothesis one, a one-way multivariate analysis of variance (MANOVA) was used. A one-way MANOVA is appropriate for this research question because this analysis identifies whether statistically significant group differences exist between two independent groups of participants on more than one dependent variable. A MANOVA tests whether mean differences among groups on a combination of dependent variables are likely to have occurred by chance (Mertler & Vannatta, 2002). In this study, the independent variable consisted of two groups, inpatient and outpatient clients’ with psychotic disorders. Three dependent variables were used, consisting of ratings on insight into having a mental disorder, insight into the need for treatment, and insight into the social consequences of the disorder (the three global insight subscales of the SUMD). Mertler and Vannatta (2002), suggest two reasons why a researcher should be interested in using more than one dependent variable when comparing treatments or
groups based on differing characteristics: (1) any worthwhile treatment will likely affect subjects in more than one way, thus the reason for additional dependent measures, and (2) the use of several dependent measures allows the researcher to obtain a more “holistic” picture and a more detailed description of the phenomenon under investigation. By measuring several dependent variables instead of only one, the chances of discovering what actually changes as a result of differing treatments, improves tremendously.

In order to statistically test hypothesis two, a multiple regression analysis was conducted to reveal whether or not the prediction model correlated with the dependent variable. This analysis was chosen because the goal of this research question was to test whether the combination of independent variables (three global insight subscales of the SUMD) significantly predicted current need for inpatient admission using the FARS (Ward & Dow, 1994). Standard multiple regression was chosen as a way of incorporating independent variables into the regression equation. This method is appropriate for analyses that attempt to discover the unique influence of each independent variable without being guided by a particular theory (hierarchical multiple regression) or solely by a statistical program for exploratory purposes (stepwise multiple regression) (Aron & Aron, 1999; Mertler & Vannatta, 2002).

Participants and Setting

In terms of minimum necessary sample size, Cohen (1992) asserts that with an alpha level of p < .05, a medium anticipated effect size, and three independent variables, at least 76 participants are required for a statistical power of .80. In another power analysis, Tabachnick and Fidell (1996) recommend that the following formula be used when estimating sample size during multiple regression analyses: N > 104 + K (i.e., the
total number of independent variables, or three in the case of this study). This more conservative estimate was used in the study to help ensure adequate statistical power; therefore, at least 107 participants were included in data analyses.

Participants for this study included 170 adult clients selected from a 12 county community mental health agency in a Southeastern state. A sample of clients with a variety of psychotic disorders was used in order to enhance the generalizability of results. The sample included clients with the following diagnoses according to criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR; APA, 2000): Schizophrenia (N = 127), Schizoaffective Disorder (N = 15), Schizophreniform Disorder (N = 2), Delusional Disorder (N = 1), and Psychotic Disorder not otherwise specified (N = 25). Participants were selected from the following treatment settings: 98 (58%) from an inpatient psychiatric hospital, 39 (23%) from a long-term residential treatment program, and 33 (19%) from an outpatient counseling program. Participants ranged in age from 18 to 79 years (M = 39.2, SD = 9.8); 95 (56%) were male and 75 (44%) were female. In terms of racial composition, 101 participants were African-American, 62 (36%) were Euro-American, and 7 (5%) were of mixed race. Participants averaged 14.3 years of treatment (SD = 8.8), 1.9 days worked during the previous month (SD = 5.8) and a monthly income of $481 (SD = $288). In general, participants shared common characteristics to psychotic clients in the general population regarding age, gender, race, years in treatment, and socioeconomic status (APA, 1997). Data included archival diagnostic and demographic information about all newly admitted clients over a continuous 6- month period. Therefore, a convenience sample was utilized from an agency data base. All diagnoses were made by a licensed professional counselor.
Delimitations

The sample population was delimited to participants assigned a DSM-IV-TR (APA, 2000) psychotic disorders listed above. All participants were above 18 years of age. These delimitations were imposed because psychotic disorders are the target population for this study, and psychotic clients less than 18 years old may have different psychosocial symptoms which are more difficult to evaluate than those manifested in adults (APA, 2000). Due to the nature of the archival data available, participants were delimited to a geographic region in the Southeastern United States. In order to help enhance generalizability of results to other client populations, delimitations were not placed on participants’ age, sex, race, income, educational background, vocational history, severity of symptoms, prior treatment history, or living status.

Procedures

Clients presented at two different mental health levels of care (i.e., inpatient or outpatient treatment settings) either voluntarily or involuntarily (in the case of some inpatient clients) due to extreme distress or significant psychosocial impairments over a continuous 4-month period. All clients participated in routine intake procedures including the collection of demographic information, a biopsychosocial history, and a family history. After obtaining written informed consent, clients participated in the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1995) to assist in accurate clinical diagnoses according to the DSM-IV-TR (APA, 2000). The SCID is a semi-structured interview approach specifically designed to assist counselors in accurately assessing and diagnosing Axis I DSM mental disorders.
Interviews were conducted by licensed master’s and doctoral-level professional counselors trained in the assessment and diagnosis of mental disorders. Only those clients with confirmed psychotic disorders diagnoses were included in the sample for the study. At the time clinical interviews were conducted and diagnoses were assigned, all counselors were blind to the purpose and procedures of this study.

Next, participants’ current psychosocial symptoms were evaluated using the Structured Clinical Interview for the Functional Assessment Rating Scale (SCI-FARS; Ward et al., 1995). The SCI-FARS is a semi-structured interview used to gain detailed information about the severity of 17 different psychosocial impairments, as measured by the FARS (Ward & Dow, 1994). Finally, clients were assessed regarding degree of insight into their illness by evaluating their awareness of having a mental disorder, consequences of the disorder, and the need for treatment. Total interview time averaged approximately 90 minutes. After each interview was completed, the interviewers privately completed the FARS (Ward & Dow, 1994) and the SUMD (Amador & Strauss, 1993).

All clinicians had been trained in the use of the rating scales cited above. Archival research data had been previously obtained and are currently the property of another researcher affiliated with the community mental health agency. Permission has been received by this researcher for use of the data set. The procedures described have been approved by the University of Akron Human Subjects Committee.

Instruments

The Scale to Assess Unawareness of Mental Disorder (SUMD; Amador & Strauss, 1993) is a 20-item semi-structured instrument used to evaluate a client’s current
degree of self-awareness (or lack thereof) related to aspects of their mental disorder. The SUMD is a multi-dimensional measure of insight. It comprises three ratings for each global insight into current and past illness: insight into having a mental disorder, need for psychiatric treatment, and consequences of the disorder. The scale also addresses 17 areas of symptom-specific insight; however, these areas were not used in this study. Only the three global insight items were used because these are the major subscales the instrument is based on; they are the most commonly used in research studies and are the most valid with psychotic clients (Schwartz, 1998c). After a semi-structured interview was completed, insight was rated according to a 5-point Likert-type scale (1 = fully aware of symptoms/mental disorder, 3 = somewhat aware of symptoms/mental disorder, 5 = unaware of the symptoms/mental disorder). Higher ratings on the scale indicate that the client has less insight into his or her psychotic disorder. The SUMD demonstrates interrater reliability, and test-retest reliability (Amador & Strauss, 1993). In recent studies, interrater agreement on the SUMD items one, two, and three were $r = .96$, $r = .94$, and $r = .97$, respectively, when two counselors simultaneously interviewed and rated the same participant (Schwartz & Smith, 2004). The instrument also demonstrates good construct validity, as documented by recent authors (Markova & Berrios, 1995).

The Functional Assessment Rating Scale (FARS; Ward & Dow, 1994) is a 17-item scale used to assess psychosocial symptoms in clients with mental disorders, especially those with psychotic disorders. After completion of a full psychosocial interview, administration time was approximately 5 to 10 minutes, and was hand-scored by the test administrator. After a clinical interview each item on the FARS was scored independently by a counselor according to a standardized 9-point rating system (1 =
absent, 3 = slight problem, 5 = moderate problem, 7 = severe problem, 9 = extreme problem). Higher scores indicate more severe impairment related to those symptoms, and ratings are based on current symptoms (i.e., within last 3 weeks). Each of the 17 items is defined in behavioral terms to enhance the reliability of the ratings. One of the psychosocial impairment items that was of focus for this study is Security/Management Needs (i.e., termed ‘need for an inpatient admission’ in this study). Security/Management Needs is operationalized as suicide watch, locked unit, behavioral contract, protection from others, involuntary exam/commitment, and seclusion due to extreme distress and/or psychosocial impairments. Higher ratings on this item indicate more immediate need for a more restrictive level of care with more external controls (i.e., inpatient treatment).

Ward and Dow (1994) report good interrater reliability on FARS items, ranging from $r = .76$ to $r = .89$. They also report good test-retest reliability and good construct validity. In a recent study of the FARS’ psychometric properties specifically testing psychotic clients, Schwartz (1999) reported interrater agreement correlations of $r = .88$, mean test-retest reliability correlations of $r = .86$ two weeks after initial assessments, mean concurrent reliability correlations of $r = .89$ (when compared with the Positive and Negative Syndrome Scale for schizophrenia), and good construct validity as evidenced by average counselor ratings of 1.3 on a 1 to 5 Likert-type scale (1 = extremely accurate/useful, 2 = accurate/useful, 3 = somewhat accurate/useful, 4 = inaccurate/not useful, 5 = extremely inaccurate/not useful). Therefore, the FARS has been shown to evidence sound psychometric properties, particularly with the client population investigated in this research study.
Summary of Methodology

The purpose of this research study was to investigate how insight among psychotic clients impacts level of care. Specifically, this researcher studied whether insight among psychotic clients differs in outpatient treatment versus inpatient treatment and whether degree of insight related to a current need for inpatient admission. Participant data were obtained archivally and participant characteristics were only delimited by their specific DSM-IV-TR (APA, 2000) diagnosis, age, and their geographic location. The research design employed was ex post facto with tests of alternative hypotheses. Data analyses used included a one-way MANOVA in order to statistically test hypothesis number one. For hypothesis two, a multiple regression analysis was used. The SUMD (Amador & Strauss, 1993) and FARS (Ward & Dow, 1994) ratings scales were used to measure insight and need for a current inpatient admission, respectively.
CHAPTER IV
RESULTS

The purpose of this chapter was to statistically investigate whether insight among psychotic clients impacted level of care. Specifically, this researcher studied whether insight among psychotic clients differed in clients in an outpatient treatment setting versus inpatient treatment, and whether degree of insight related to current need for inpatient admissions. This chapter presented the statistical results of the study. The chapter is organized into two sections: descriptive statistics and inferential statistics. The descriptive statistics section describes frequency distributions for participants’ demographic characteristics. Inferential statistics were utilized to test the research hypotheses. This chapter concludes with a summary of the results.

Descriptive Statistics

A total of 170 adult clients with psychotic disorders were recruited for this study. Ninety-eight (58%) clients were selected from an inpatient psychiatric hospital, 33 (19%) were drawn from an adult outpatient program, and 39 (23%) were recruited from a partial hospitalization program. Both the outpatient and partial hospitalization clients were being treated on an outpatient basis and were therefore combined in the ‘outpatient’ group for statistical analysis purposes. Of the total sample, 101 (59%) identified as African-American, 62 (36%) identified as Euro-American, and 7 (5%) identified as
mixed race. Regarding the entire sample, clients ranged in age from 18 to 79 years (Mean = 39.2, SD = 9.8). Ninety-five (56%) were male and 75 (44%) were female.

Instruments used in this study included the Scale to Assess Unawareness of Mental Disorder (SUMD; Amador & Strauss, 1993) which includes three global insight scales (i.e., insight into having a mental disorder, insight into the social consequences of the disorder, and insight into the need for treatment) and the one subscale from the Functional Assessment Rating Scale (FARS; Ward & Dow, 1994). Table 1 displays descriptive statistics for participants’ ratings on these instruments.

Table 1
Descriptive Statistics for Independent and Dependent Variables ($N = 170$)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUMD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insight into mental disorder</td>
<td>1.00</td>
<td>5.00</td>
<td>2.95</td>
<td>1.61</td>
</tr>
<tr>
<td>Insight into social consequences</td>
<td>1.00</td>
<td>5.00</td>
<td>3.15</td>
<td>1.64</td>
</tr>
<tr>
<td>Insight into need for treatment</td>
<td>1.00</td>
<td>5.00</td>
<td>2.32</td>
<td>1.60</td>
</tr>
<tr>
<td><strong>FARS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for inpatient admission</td>
<td>1.00</td>
<td>9.00</td>
<td>2.38</td>
<td>1.93</td>
</tr>
</tbody>
</table>

As noted in Table 1, all ratings on the global insight scales ranged from 1 to 5, with higher ratings demonstrating less insight (i.e., 1 indicates a great degree of insight...
and 5 indicates no insight). The SUMD item assessing insight into the social consequences of the disorder received the highest score with a mean of 3.15. This indicated that participants had the least insight in this area. Among the insight areas measured, participants manifested the most awareness of the need for and benefit of treatment. Participants demonstrated a moderate degree of insight related to having a mental disorder. On average, participants as a whole demonstrated a slight need for inpatient admission. Table 2 displays descriptive statistics for SUMD scores between the two groups of participants (i.e., inpatient versus outpatient clients).

Table 2
Descriptive Statistics for SUMD Scores Among Inpatient and Outpatient Clients

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Clients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insight into mental disorder</td>
<td>3.57</td>
<td>1.51</td>
<td>54</td>
</tr>
<tr>
<td>Insight into social consequences</td>
<td>3.50</td>
<td>1.66</td>
<td>54</td>
</tr>
<tr>
<td>Insight into need for treatment</td>
<td>3.07</td>
<td>1.77</td>
<td>54</td>
</tr>
<tr>
<td><strong>Outpatient Clients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insight into mental disorder</td>
<td>2.65</td>
<td>1.57</td>
<td>116</td>
</tr>
<tr>
<td>Insight into social consequences</td>
<td>2.98</td>
<td>1.61</td>
<td>116</td>
</tr>
<tr>
<td>Insight into need for treatment</td>
<td>1.96</td>
<td>1.39</td>
<td>116</td>
</tr>
</tbody>
</table>
As shown in Table 2, inpatient participants averaged less insight (i.e., higher SUMD ratings) on all three subscales than outpatient participants. Insight into the need for and benefits of treatment was most poignantly different between the two groups (3.07 for inpatient participants versus 1.96 for outpatient participants). However, given the standard deviation of SUMD ratings, participants in both groups varied widely in their degree of insight related to all three SUMD items assessed.

**Inferential Statistics**

Hypothesis one stated that there would be no statistically significant differences in psychotic clients’ degree of insight, as measured by the SUMD (Amador & Strauss, 1993), based on clients’ current level of care (inpatient versus outpatient treatment). In order to statistically test hypothesis one, a MANOVA was conducted to compare the two groups of participants regarding ratings on the three global insight SUMD subscales.

Before MANOVA was used, a Box’s Test was performed in order to test possible violations of statistical assumptions needed for MANOVA. In terms of testing whether statistical assumptions of MANOVA hold, typically a Box’s Test is significant at $p \geq .001$. If this is the case, then robustness of the analysis cannot be assumed due to unequal variances among groups (Mertler & Vannatta, 2002). Results of a Box’s Test were not statistically significant using common cut-off scores, $F = 2.26$, $p = .04$. Therefore, a violation of homogeneity of variance-covariance was not found and the main assumption for MANOVA was held. However, in order to be cautious about interpretation of MANOVA results, the researcher chose to use a more conservative Pillai’s Trace statistic to interpret the results (as opposed to the more common but less stringent Wilks’ Lambda statistic) (Mertler & Vanatta, 2002). Table 3 shows results for the Pillai’s Trace
MANOVA results. As shown in Table 3, results of the MANOVA were statistically significant, $F(3, 166) = 7.15, p < .001$. This result indicated that some or all of the SUMD insight subscales differentiated inpatients from outpatients.

Table 3

Results for MANOVA Differentiating Degree of Insight Among Inpatient and Outpatient Clients ($N = 170$)

<table>
<thead>
<tr>
<th>Effect</th>
<th>Value</th>
<th>F</th>
<th>Hypothesis df</th>
<th>Error df</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admstatu</td>
<td>.114</td>
<td>7.15</td>
<td>3</td>
<td>166</td>
<td>.0001</td>
<td>.114</td>
</tr>
</tbody>
</table>

Note. F statistics are exact.

Due to the results reported above a follow-up univariate ANOVA was used to determine which dependent variable (i.e., insight) resulted in significant MANOVA results. Results of the ANOVA revealed that both insight into the need for treatment ($F = 19.53, p < .001$) and insight into having a mental disorder ($F = 12.89, p < .001$) differentiated inpatient participants from outpatient participants. Less insight in both of these areas was associated with inpatient participants. Insight into the social consequences of the disorder did not significantly differentiate the two groups of participants. Table 4 shows results of the ANOVA for hypothesis one.
Hypothesis two stated that there would be no statistically significant relationship between degree of insight, as measured by the SUMD (Amador & Strauss, 1993), and current need for inpatient admission, as measured by the Functional Assessment Rating Scale (FARS; Ward & Dow, 1994). In order to statistically test hypothesis two, a multiple regression analysis was conducted to reveal whether or not the predictor variables (i.e., insight) correlated with the dependent variable.

Results of the multiple regression analysis indicated that the overall model including all three predictor variables was statistically significant, $F(3, 166) = 4.54, p = .004$. $R^2 = .08$, indicating that 8% of the variance in ratings on need for inpatient admissions was accounted for by the three types of insight tested here. Cohen (1992)
explains that this is a small effect size. Follow-up t-tests revealed that only one independent variable (insight into the need for treatment) significantly predicted current need for inpatient admission, $t = 2.03, p = .04$. This result suggests that insight into the need for treatment significantly predicted current need for inpatient admissions, even after controlling for the effects of the other two types of insight. The positive correlation found between the independent and dependent variable shows that as insight becomes poorer (i.e., higher SUMD scores), need for inpatient admission becomes more necessary (i.e., higher ratings on the FARS). A summary of regression coefficients for each of the predictor variables is presented in Table 5.

Table 5

Summary of Coefficients for Predictor Variables ($N = 170$)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insight into mental disorder</td>
<td>.22</td>
<td>.18</td>
<td>1.68</td>
<td>.10</td>
</tr>
<tr>
<td>Insight into social consequences</td>
<td>-.18</td>
<td>-.15</td>
<td>-1.55</td>
<td>.12</td>
</tr>
<tr>
<td>Insight into need for treatment</td>
<td>.24</td>
<td>.19</td>
<td>2.03</td>
<td>.04*</td>
</tr>
</tbody>
</table>

Note. * $p < .05$
CHAPTER V
DISCUSSION

Chapter V discusses the results of the study. This chapter is organized into five sections: descriptive summary and interpretations of statistical results, discussion of the results of this study to related/previous research, implications for clinical practice, implications of the results applied to Counselor Education and Supervision, and limitations of the study and recommendations for future research.

Descriptive Summary and Interpretation of Statistical Results

The purpose of this present study was to statistically investigate whether insight among psychotic clients impacted level of care. Participants in this study consisted of two independent groups from different treatment settings: clients diagnosed with psychotic disorders in an outpatient level of care and clients with psychotic disorders in an inpatient level of care. Total sample size was 170 adult clients of multiple races (i.e., African-American, Euro-American, and mixed race); ages ranged from 18 to 79 years, and both males and females were approximately equally represented.

Hypothesis one stated that there would be no statistically significant difference in psychotic client’s degree of insight, as measured by the SUMD (Amador & Strauss, 1993) based on client’s current level of care (inpatient versus outpatient treatment). Results showed that there was a statistically significant difference in insight, as measured by the SUMD (Amador & Strauss, 1993) between inpatient and outpatient levels of care.
among clients diagnosed with psychotic disorders. A follow-up ANOVA was used to
determine which dependent variables (i.e., insight) resulted in significant MANOVA
results. Results of the follow-up ANOVA revealed that both insight into the need for
treatment ($F = 19.53, p < .001$) and insight into having a mental disorder ($F = 12.89, p < .001$) differentiated inpatient clients from outpatient clients. Less insight in both of these
areas was associated with inpatient treatment.

Hypothesis two stated that there would be no statistically significant relationship
between degree of insight, as measured by the SUMD (Amador & Strauss, 1993) and
current need for inpatient admission, as measured by the FARS (Ward & Dow, 1994).
This hypothesis was tested by using multiple regression as the statistical analysis to
predict whether the combination of independent variables (i.e., three global insight
subscales of the SUMD) significantly predicted current need for inpatient admission
using the FARS (Ward & Dow, 1994). Results indicated that the overall model including
all the predictor variables was statistically significant, $F(3,166) = 4.54, p = .004, R^2 = .08,$
indicating that 8% of the variance in ratings on need for inpatient admissions was
accounted for by the three types of insight tested. Due to the small effect size (Cohen,
1992) follow-up t-tests revealed that only one independent variable (i.e., insight into the
need for treatment) significantly predicted current need for inpatient admission, $t = 2.03,$
$p = .04$ when controlling for the influence of the other variables. This result suggests that
insight into the need for treatment significantly predicted current need for inpatient
admissions, even after controlling for effects of the other two types of insight.

In general, the results of the MANOVA for hypothesis one were similar to those
in the related literature, which has indicated that there is a difference in insight between
inpatient and outpatient levels of care among clients diagnosed with psychotic disorders. Research on inpatient admissions among psychotic clients showed similar results in that clients in this treatment setting demonstrated poorer insight at baseline and often had multiple readmissions. Results across studies identified poor insight as a risk factor for hospitalizations. Results of research on insight and post-hospitalization discharge status among psychotic clients generally showed that only modest improvements were made with regard to awareness of illness. Insight varied depending on the course and phase of illness among the participants in the studies. Results of research on insight and outpatient treatment settings also showed that insight deficits exist even among stable clients in an outpatient setting; however, the more chronic the illness, the worse insight seems to be. Findings suggest that early insight serves as an instrumental role in the prevention of psychological decompensation and possible hospitalization.

Results from a follow-up ANOVA revealed that insight into the need for treatment and insight into having a mental disorder, differentiated inpatient clients from outpatient clients. The results from the current study were, in general, similar to prior research. However, there have been very few studies that looked at different dimensions of insight. Of the two studies that did examine different dimensions of insight, results of both studies supported that need for treatment differentiated inpatient clients from outpatient, while only one study supported results of the current study that insight into having a mental disorder differentiated inpatient clients from outpatient clients.

Due to lack of empirical research regarding degree of insight and current need for inpatient admission, there is no current literature base with which to compare results from hypothesis two. This is the first empirical study to examine this hypothesis. While no
direct empirical research exists currently, findings from one study has supported that participants found to be uninsightful required hospitalization. (i.e., as degree of insight decreases, need for inpatient admission increases).

Comparison of Results of This Study to Previous Research

In Chapter II, results of literature on insight and level of care were reviewed and empirical findings were reported. The literature review was broken down by empirical research that examined insight and its relationship to different levels of care. The following compares results of current study findings to previous research findings from most restrictive to least restrictive treatment environments.

Hypothesis one results showed that there was a statistically significant difference in insight, as measured by the SUMD (Amador & Strauss, 1993) between inpatient and outpatient levels of care among clients diagnosed with psychotic disorders. Furthermore, results of the follow-up ANOVA revealed that both insight into the need for treatment and insight into having a mental disorder differentiated inpatient clients from outpatient clients. Less insight in both of these areas was associated with inpatient treatment. This finding is consistent with research conducted by Draman et al. (2005) that found insight was one among other variables/risk factors for repeated admissions. McEvoy et al. (1989c) also found similar findings in that lack of insight is associated with re-hospitalization. Similarly, Kelly et al. (2004) attempted to identify predictors of involuntary admission in first episode Schizophrenia. Results showed that lack of insight predicted involuntary admission status in first episode Schizophrenia.

McEvoy et al. (1989b) examined the relationship between insight and psychopathology in a group of clients who met DSM-III criteria for Schizophrenia or
Schizoaffective Disorder. Approximately half of the participants were admitted to the hospital on a voluntary basis and the other half were admitted involuntarily. All participants were rated by the ITAQ (McEvoy et al., 1989a) to assess degree of insight. Findings strongly supported clinical intuition in that voluntary and involuntary clients differed in degree of insight into their illness and need for treatment. Clients, who were involuntarily admitted, displayed significantly lower insight ratings at the time of admission, relative to voluntarily admitted clients. Even though clients’ status at the time of admission (i.e., voluntary versus involuntary) was not tested/examined in this study, results of the study mentioned above support that insight is significantly lower for those clients in need of involuntary hospitalization. Furthermore, results from the study by McEvoy et al. that degree of insight into illness and need for treatment differentiated inpatient clients from outpatient clients are similar to findings from the current study and support hypothesis one. In addition, results from Weiler et al. (2000) also revealed a strong relationship between insight deficits and initial involuntary hospitalization status. These authors report that poor insight could be interpreted as less problematic or common among clients entering outpatient treatment (i.e., those being discharged from the inpatient setting).

In yet another study conducted by Kemp and Lambert (1995), researchers examined the relationship between symptoms and insight in a cross-sectional analysis at different points in the treatment process. Participants were administered a modified version of the SUMD (Amador & Strauss, 1993). Average scores on the insight subscales were poor at admission; however, results showed gains in insight over the hospitalization period. These results further support findings from the current study.
(hypothesis one) that acute inpatient clients have poorer insight than those ready for discharge (i.e., those who will soon be outpatient clients).

Results of empirical research findings that examined insight and post-hospitalization discharge status among psychotic clients generally showed that only modest improvements were made with regard to awareness of illness. Furthermore, findings described lack of insight as a prevalent feature of functional psychoses even in cross sectional studies. For example, in a study by Smith et al. (2003), researchers assessed changes in symptom awareness in a sample of clients diagnosed with Schizophrenia or Schizoaffective Disorder. Participants were followed over a 6-month period after inpatient treatment for an acute symptom exacerbation. With regard to insight, researchers found that insight did not change appreciably in the early stages of outpatient treatment in individuals with Schizophrenia.

Results of another study by Fennig et al. (1996) found similar results. In this study the researchers examined the “prevalence, 6-month temporal stability and demographic correlates of insight in a diagnostically heterogeneous sample of psychotic clients during their first hospitalization” (p. 258). Results indicated that very few clients with psychotic disorders had insight into their illness. At the 6-month follow-up, a substantial number of clients with psychotic disorders lacked insight. The authors reported that lack of insight appeared to be associated with presence of psychosis at the height of the episode, but was differently distributed by diagnosis later in the 6-month course. Cuesta et al. (2000) investigated whether insight changed with time, and how it related to clients’ psychopathology. Results at baseline assessment showed that a large proportion of clients had a moderate to severe lack of insight, depending on which insight
measure was used (i.e., between 49% and 66%). At follow-up assessment, between 29% and 49% of these clients continued to have fair to poor insight. These results indicated that level of insight into illness did not significantly improve over time in clients suffering from functional psychoses. Similarly, findings from Smith et al. (1998) suggest that insight deficits in Schizophrenia vary depending on factors such as course and phase of illness in their cross-sectional and longitudinal research.

Results of empirical research findings, that examined insight and outpatient treatment status among psychotic clients, also showed that insight deficits exist even among stable clients in an outpatient setting; however, the more chronic the illness, the worse insight appears to be. Findings suggested that early insight serves as an instrumental role in the prevention of psychological decompensation and possible hospitalization. For example, in one of the earlier studies examining insight in an outpatient setting, Heinrichs et al. (1985) studied early insight in a group of 39 psychotic clients who met criteria for Schizophrenia or Schizoaffective Disorder. Findings supported the hypothesis in that a greater percentage of participants who demonstrated early insight required less frequent hospitalization. A greater percentage of those participants found to be uninsightful required hospitalizations. While the focus of the current study was not specifically on “early insight,” findings from Heinrichs et al. support findings from this study that there is, in fact, a difference in insight between inpatient and outpatient levels of care. Furthermore, while the study by Heinrichs et al. did not examine level of insight and current need for inpatient treatment, findings showed that participants found to be uninsightful required hospitalization. This supports the
results of hypothesis two which states that as degree of insight decreases, need for inpatient admission also increases.

In a study by Dickerson et al. (1997), researchers examined the prevalence of insight among outpatients diagnosed with Schizophrenia or Schizoaffective Disorder. Results demonstrated that in general, insight into illness was at least moderately impaired (49.5%), and 25% of participants had severe insight deficits. Furthermore, those clients who received professional residential supervision had more insight deficits than those who did not receive those services. This supports results from the current study that more severe deficits in insight require a higher level of care (i.e., residential supervision).

Results from a study by Kim et al. (1997) also supported findings from current research. These results showed that awareness of the need for treatment was significantly higher in an outpatient group versus an inpatient group and was not correlated with other variables in the study. Results from this study directly support hypothesis one that need for treatment differentiates inpatient clients from outpatient clients, and that less insight into the need for treatment is associated with inpatient care. Kim et al. noted most studies reporting poor insight in Schizophrenia sampled clients with acute Schizophrenia, whose symptoms may have impaired their awareness of illness. On the contrary, reports about intact insight in Schizophrenia come from chronic samples. Further research in this area is warranted focusing more specifically on types/specifies of Schizophrenia to assess differences in insight in a chronic versus acute sample. Similar results were found in yet another study by Yen et al. (2002). These researchers also found that better insight into the need for treatment was associated with fewer hospitalizations; however, insight into mental illness or psychotic experience was not. These results partially support findings
from the current study as both need for treatment and insight into having a mental disorder were found to differentiate inpatient clients and outpatient clients.

In a final study on insight among outpatient psychotic clients, results from Mintz et al. (2004) showed that 64% of first-episode clients demonstrated good insight at the initial assessment, and 79% at the one-year follow up. These results support current findings that outpatient clients have a higher degree of insight. These results run contrary to previous studies that reported less than half their sample demonstrated good insight (Fennig et al., 1996). Again, more specific information with regard to chronicity and acuity is needed in order to compare results more appropriately.

Implications for Clinical Practice

Schizophrenia ranks among the top 10 causes of disability in developed countries worldwide (World Health Organization, [WHO], 2001). More than two million Americans are affected by Schizophrenia in any given year (National Institute of Mental Health, 2002) and these individuals are treated by clinicians in both the private and public sectors. Poor insight has been noted as an associated symptom of psychosis and psychotic disorders (APA, 2000), being especially prevalent in Schizophrenia (Amador et al., 1994). Therefore, it is incumbent upon mental health professionals in clinical practice to understand the role that insight plays in effectively assessing and treating individuals with psychotic disorders.

The construct of insight can be a valuable tool for clinicians working with clients having psychotic disorders. An assessment of client insight can aid clinicians in gaining a better understanding of clients’ awareness of having a mental illness. Clinicians can plan appropriate interventions to meet the client’s unique treatment needs, assess whether
or not clients will understand the benefits of treatment, and predict which clients are more likely to adhere to treatment (Schwartz, 1998a). Ultimately, this knowledge is often what leads clinicians to make treatment and level of care decisions on behalf of clients if they are unable to make those decisions for themselves; therefore, insight is a critical tool for clinicians to utilize in making clinical recommendations or determinations.

In order for clinicians to utilize the construct of insight as a screening measure to make treatment decisions and level of care determinations, it is equally important that clinicians are trained to assess insight. Currently, assessment of insight is not a common practice in public health sectors. While assessment of psychotic clients’ overall needs and treatment recommendations is routinely assessed in the public sector, evaluation of degree of insight is not usually a formal part of mental health assessments. Since results of research has shown insight to be a predictor of hospitalizations, as well as a correlate of several outcome variables, it is only logical that the measurement and assessment of insight become a routine part of mental health assessments and an ongoing part of treatment. Therefore, it is vital that clinicians become competent in reliable, consistent assessment of insight and provide ongoing assessment of insight in making treatment decisions.

Results from research have established relationships between impaired insight, lack of adherence to treatment, and medication noncompliance, (Kemp & David, 1996b) which often leads to a relapse and the need for more restrictive care. Lack of insight may result in medication noncompliance, which places a client at risk for hospitalization. To deliver the sort of protections needed against relapse, all risk factors must be examined by clinicians. In a study by Weiden, Kozma, Grogg, and Locklear (2004) results
indicated that lower compliance with medication was associated with a greater risk for hospitalization over and above any other risk factor for hospitalization. If clinicians could intervene before this occurs, they may be able to apply prevention strategies to avoid a relapse and the need for more restrictive care. This would also drastically reduce the cost of more restrictive care to an already overburdened healthcare system.

The degree to which a client with Schizophrenia acknowledges that he or she has a mental illness and needs treatment (i.e., insight into the mental disorder and its consequences) has consistently been found to predict how readily that individual will cooperate with treatment. Clients with little or low insight in an outpatient or inpatient setting are less likely to comply with treatment and more likely to require hospitalization (David, 2004). A clinician’s identification of poor insight may improve treatment outcome by pinpointing early warning signs and triggering therapeutic interventions. Clinicians should be aware of how insight (or lack thereof) in clients impacts treatment and treatment compliance so they can plan interventions appropriately. Lack of insight may be a barrier to medication and/or treatment compliance, and thus clinicians want to plan interventions to increase insight, or use insight as a screening tool to assess level of care.

Insight relates to many outcome variables such as treatment compliance, medication compliance, and voluntary versus involuntary hospitalization, as previously stated. While insight plays an important role in the treatment of clients with Schizophrenia, it is one of many variables that impacts treatment and prognosis for clinicians to be cognizant of and may be confounded by factors such as cognitive and executive dysfunction (David, 2004).
It is just as critical for outpatient clinicians to understand the role of insight and its relationship to outcome variables (i.e., treatment adherence, medication adherence, hospitalization) as it is important to assess the role of insight while clients are hospitalized in order to make appropriate discharge decisions. One indicator for basing hospital discharges is on reduction or stabilization of psychotic symptoms. While this is a favorable outcome, clients who have a lower degree of insight and by definition lack awareness of their mental disorder, the social consequences of the disorder and the need for treatment may not continue with ongoing treatment recommendations (which includes medication adherence) upon hospital discharge, thus increasing the chances of further decompensation which may result in another hospitalization. Therefore, it is also important for clinicians to consider the role of insight for hospital discharges and plan for appropriate medication and therapeutic interventions upon hospital discharge to avoid future rehospitalizations. For example, clients with chronic mental illnesses and lack of insight, who do not adhere to daily medication routines may have more success with long acting injectable antipsychotic medications (McEvoy, 2004).

Clients, who lack insight, also often lack an awareness of the need for treatment. Therefore, they may not seek out treatment nor consent to treatment, ultimately placing themselves at higher risk for relapse and hospitalization. Clinicians need to be able to accurately assess a client’s refusal of treatment and determine whether client’s lack of insight results into refusal of treatment putting themselves or others at risk necessitates a higher level of supervision and care (i.e., residential treatment, hospitalization.) It is essential for clinicians to be able to make these determinations about level of care when
clients are unable to do so for themselves. This may result in an involuntary hospitalization.

Schizophrenia is recognized as a brain disorder, with a neurobiological basis, that is expressed in severe psychotic episodes that impair the ability to accurately perceive and interpret reality. However, this illness is treatable and, at least partially responsive to available medications (Husted, 1999). A major dilemma exists in the expectation that clients, who suffer from psychotic disorders, and who lack insight, must depend upon insight to make reasonable decisions about their need for treatment, oftentimes when they are most ill. Usually no treatment is sought out by these individuals. These times are when it is most critical that clinicians intervene to make decisions on behalf of clients about their care, when they are of danger to themselves or to others. Client education should be a basic part of any treatment plan to improve compliance for those clients who are able to understand their mental illness, understand the factors that cause their symptoms, the consequences of the disorder, and the need for ongoing treatment. Another factor is gathering information from family members and other collaterals about the clients’ mental health status and changes in status. This information is often critical in making level of care determinations (Husted, 1999).

Methods for directly improving insight through psycho-education and cognitive rehabilitation are critical and hold great promise that improvements in insight will translate into improvements in treatment compliance and medication compliance, ultimately decreasing the need for hospitalization and increasing favorable outcomes. Psycho-education focused on identification of symptoms of mental illness, medication management, relapse prevention, skill building, etc. can be helpful in giving clients
knowledge and resources to assist them in their recovery process and prevent relapse and hospitalization (Rosotto, Wirshing, & Liberman, 2004). In addition, case management services may be helpful for those clients that are in need of ongoing monitoring, closer supervision of medication compliance, objective symptom monitoring, and assessment of activities of daily living in order to remain in less restrictive levels of care and assess if more restrictive levels or care are needed (Husted, 1999).

There have been attempts to improve insight in individuals with severe psychiatric disorders in an attempt to improve medication compliance. These efforts have included cognitive behavioral therapy (David, Kemp, Kirov, Everitt, & Hayward, 1998), video self-observation (Davidoff, Forester, Ghaemi, & Bodkin, 1998) and use of specific anti-psychotics claimed to be especially effective in improving insight (Pallanti, Quercioli, Pazzagli, 1999). In a study by Turkington et al. (2006), results showed that a sample of community based clients, with Schizophrenia, who received cognitive behavioral therapy, had significantly more insight at 1-year follow-up. Brief therapy protected against depression with improving insight and reducing risk of relapse. Furthermore, results indicated that these clients spent significantly reduced time in the hospital even for those who did relapse and delayed time to admission. These results support the notion that insight can be increased for some clients, who suffer from Schizophrenia, and hospitalization and length of stay can be reduced.

While some clients will make positive gains with increased insight through psycho-education and therapy, there will still be a significant proportion of clients who lack insight and an understanding of their illness sufficient to adhere to necessary and appropriate treatment. While psycho-education may not be an intervention that proves to
be successful for all clients, it is a relapse prevention measure that will work for certain clients.

Insight into illness has also been associated with increases in depression and suicidality. Researchers who have studied the association between insight and psychotic symptomology (Schwartz et al., 2000) generally agree that increased insight may exacerbate key symptoms which precede suicidality in some clients. For example, in a study by Amador et al., (1996) results found that clients’ awareness of their asociality, anhedonia, and blunted effect correlated with more extreme suicidality. Schwartz (1999a) similarly found that as insight into the need for treatment increased, reports of suicidality also increased. In yet another study, Schwartz and Smith (2004) found that increased insight into psychotic illness and more severe depressive symptoms significantly heightened clients’ risk of suicidality. Siris (2001) suggests that awareness of illness should be considered a primary factor in the study of suicide risk factors for psychotic disorders. Therefore, clinicians must be prepared to continually assess depression and suicidality as insight increases and provide appropriate intervention

It is not only critical for clinicians to understand the role of insight in level of care determinations, but also for managed care companies to be informed of the benefits of higher levels of care that are often necessary to treat individuals with mental illness. With the movement of deinstitutionalization beginning in the 1950s and continuing into the mid 1980s (Boardman, 2006), the growing trend has been for individuals with severe and persistent mental illness to reside and be treated in their community settings. While newer antipsychotic medication and treatment protocols have helped to enhance clients’ ability to reside in community settings, it is also critical that clients who do need a higher
level of care, receive that level of care until they are stabilized and the risk of further
decompensation is significantly reduced.

As managed care continues to have a strong presence and impact on the
behavioral health care delivery, the emphasis for efficient and cost-effective level of care
decisions will be paramount. As might be expected, managed care’s rapid expansion has
been paralleled by concerns about the impact of cost-controlling strategies on the delivery
of mental health services. Managed care companies’ cost-controlling strategies, coupled
with dramatic reductions in length of inpatient stays, have elicited concerns that the
emphasis on cost-containment may be overshadowing attention to client care (Lyons et
al., 1997). Level of care decisions should be based on “service needs” of individual
clients (i.e., medical necessity). Shortsighted attempts to limit expenditures can lead to
overall increases in expenditures in the care of psychotic clients.

A critical issue in bridging the gap between appropriate levels of care for specific
clients is increased coordination among outpatient and inpatient providers to assess level
of care needs for individuals with psychotic disorders and to understand the role of
insight as a screening factor as well as discharge criterion. Lack of coordination and
cooperation between services is the result of, and one of the main reasons for, the
revolving-door phenomenon among persistently mentally ill clients (Rossler et al., 2005).
Community reintegration efforts should be a collaborative effort between inpatient and
outpatient clinicians and appropriate interventions should be planned for those clients,
with little or no insight, in order to remain engaged in ongoing treatment.
Implications for Counselor Education and Supervision

In terms of implications for counselor education and training, it is important for Counselor Educators to be knowledgeable about the role of insight in treating psychotic disorders, in order to properly educate and train students and supervisees. Students and counselor trainees need to be appropriately trained, regarding the role of insight and its relationship to variables such as medication compliance, treatment compliance, hospitalization, symptomatology, and psychosocial functioning, in order to plan and provide effective therapeutic interventions and services to their clients. Students and counselor trainees should also be trained to assess level of care needs and provide interventions to aid in the prevention of relapse and avoid hospitalization.

With a lifetime prevalence rate for all psychotic disorders at approximately 2% of the population (APA, 2000), many clients will present with psychotic symptoms. The first step is for students-in-training and counselor trainees to know how to appropriately diagnose these individuals so that appropriate treatment planning can occur. Therefore, it is critical that Counselor Educators train future counselors in appropriate diagnosis and recognition of symptoms of psychotic disorders. This would entail educating on the grouping of psychotic disorders in general, but more specifically how to differentiate among different psychotic disorders. Diagnostic courses should also teach counselors-in-training about the associated features of psychotic disorders. As noted in the DSM-IV-TR (APA, 2000), “... poor insight is a manifestation of the illness” (p. 304).

Counselor Educators can certainly remain on the forefront of helping students understand the role of insight in psychotic disorders; however, the second step is for students to be trained in appropriate assessment of insight. Counselor Educators should
emphasize that insight is not a unitary concept but rather a multidimensional phenomenon. Students and counselor trainees would benefit from being trained on multidimensional measures of insight and how to use these measures to assess insight on an ongoing basis in a reliable and consistent manner. Consequently, this teaching should carry over to treatment courses, where students can be trained on how insight in psychotic disorders impacts treatment. Through treatment planning courses, students can be trained on appropriate treatment planning strategies to provide a framework for therapeutic intervention. Results of research that has focused on increasing insight suggest that repetitive training and education, specifically education about one’s illness has helped to improve insight. Basic client education should be a part of any treatment plan to help improve compliance, as well as client outcomes. Cognitive-behavioral interventions have also shown some success with improving insight (Husted, 1999). During internships and practica, if counselor trainees are working with psychotic clients, supervisors should focus on helping students gain an understanding about the value and process of assessing insight.

Counselor Educators need to help students recognize insight as one of several factors that can lead to nonadherence with treatment and medication, which may ultimately lead to a relapse and hospitalization (McEvoy, 2004). Counselor Educators can train students how to apply appropriate intervention strategies before a higher level of care becomes necessary. This not only cuts costs to an overburdened economy, but helps individuals from losing their freedom. Students and counselor trainees should be taught how appropriate assessment of insight can aid in making level of care determinations. Research has shown that interventions based on clients’ individualized need, including
psychoeducation such as signs and symptoms of mental illness, medication management, and relapse prevention skills can help to improve insight and therefore, ultimately reduce the need for a higher level of care (Husted, 1999). Counselor Educators should also train students and counselor trainees about treatment interventions, including best practices and evidence-based therapeutic modalities, such as cognitive–behavioral therapy in order to enhance outcomes.

Students and future counselors need to understand how to properly assess insight, plan and implement appropriate interventions, and make level of care determinations based on degree of insight. Through education that provides diagnostic, assessment, and treatment planning and intervention skills, Counselor Educators have the opportunity to provide students and future counselors with the necessary skills and clinical tools they need to feel confident providing direct services to clients with psychotic disorders. Through appropriate assessment and intervention future counselors can help enhance outcomes and quality of life for those suffering from psychotic illnesses.

In addition to Counselor Educators preparing counselor trainees to understand the role of insight in psychotic disorders and making level of care determinations, supervisors of beginning counselors also have a critical role. Appropriate supervision of counselors is paramount. Through these supervised experiences, in which counselors obtain direct service experience, supervisors can now help counselors put into practice the diagnostic, assessment, and treatment planning and intervention skills they have learned about working with psychotic disordered clients. Hands-on supervision of beginning counselors can truly provide them with rudimentary skill building and ongoing crystallization of skills. Supervisors should take opportunities to observe counselors
applying these skills in working with psychotic clients in order to look for teaching opportunities to assist counselors in appropriate assessment of insight and how to utilize insight to determine level of care. Through ongoing supervision, counselors can be trained further on insight and its relationship with other treatment variables and the role insight plays in level of care.

Supervisors should train counselors about the continuum of care available to clients and how to appropriately assess which level of care would be best suited for clients, based on individualized needs and where they are in the course of their illness. For example, clients, who have a greater degree of insight, often can be treated in an outpatient setting. Research has shown that clients, with higher levels of insight, often display higher global functioning, psychosocial functioning, and compliance with medication and treatment (Kemp & David, 1996b; Lysaker & Bell, 1995; Schwartz et al., 1997). Numerous studies have shown that lack of insight, or poor insight, often leads to inpatient care and an increased number of hospital readmissions (Schwartz, 1998a; Draman et al., 2005). Counselors need be trained that hospitalization is not the only option for clients who begin to experience heightened or increased symptoms, and that appropriately planned interventions could help to prevent a relapse and/or hospitalization. Supervisors can train counselors in the identification of early warning signs and psychoeducation and cognitive behavioral interventions aimed at improving insight. In addition, training in good clinical judgment, which may include increase in service provision, closer monitoring, and continual assessing level of care needs can lead to unnecessary decompensation and relapse. Clients do not have to be demoralized by a
psychiatric decompensation if counselors develop appropriate skills to assess and intervene, before relapse occurs.

Supervisors can also help counselors understand the multidimensional continuum of insight. When counselors work with clients who have been diagnosed with psychotic disorders, counselors need to examine multidimensions to fully conceptualize insight and use this phenomenon to plan interventions and make level of care determinations. Supervisors can help counselors to identify valid, reliable, multidimensional measures of insight, as well as train them on the use of these measures. While there are numerous scales that measure insight, supervisors need to train students to understand the differences between unitary measures and more comprehensive, multidimensional measures of insight in order to capture the complex and dimensional nature of insight. For example, the SUMD (Amador & Strauss, 1993) currently viewed as the most reliable and valid measure of insight in psychosis (Schwartz, 1998c), offers a multidimensional measure of insight with a systematized scoring method to rate responses to controlled stimuli after use of the semi-structured interview.

Results from this study revealed that both insight into the need for treatment and insight into having a mental disorder differentiated outpatients from inpatients. Less insight in both of these areas was associated with and increased risk of inpatient status. Findings from this study emphasize and support the contention that insight is a multidimensional phenomenon rather than a unitary concept. Results of hypothesis two showed that insight into the need for treatment significantly predicted current need for inpatient admission. In this sample as insight decreased, the need for inpatient services increased. These results demonstrate that insight plays a role in level of care and should
be a factor to consider in making level of care determinations. This would be important for counselors to understand, so they can assess insight on an ongoing basis and utilize insight as a screening measure for more restrictive levels of care. Historically, insight has not been used by clinicians in making level of care determinations, clinicians have instead used level of risk to self or others, as well an increased symptomatology as a screening factor for higher levels of care. These findings suggest insight also plays a factor in level of care and that clinicians should evaluate insight in addition to other factors in making recommendations.

Limitations and Implications for Future Research

Although statistically significant results were found, this current study has several limitations that should be addressed. The sample used in this study was a sample of convenience. While achieving true random selection is difficult in social sciences, efforts to broaden external validity are recommended for future research (Heppner, Kivlighan, & Wampold, 1999). Although all newly admitted clients with psychotic disorder diagnoses over an extended period of time were included in the sample population, it is unclear whether these clients were truly representative of the larger state or national population of psychotic clients. Participants in the study also came exclusively from a semi-rural setting; therefore, generalizability to a more urban setting may be limited. Because psychotic disorders are more common in urban rather than rural locations (APA, 2000), it is possible that client symptoms, presentations, treatment histories or other factors may differ based on geographic location. In order to enhance generalizability to other settings (i.e., urban communities) it is recommended that this study be replicated while including a more diverse sample with clients represented from different geographic regions. In
particular, it would be helpful for insight and level of care to be studied in Eastern, Western and Southern metropolitan areas.

Although this study focused on discrete variables of interest (i.e., degree of insight and level of care), several other potential factors may have been present which could have influenced results. For example, between-group demographic differences in variables such as gender, socio-economic status, age of onset of illness, and education were not examined here. The use of archival data limited the variables possible to investigate statistically. Although no evidence is readily apparent regarding demographic differences in the inpatient versus outpatient groups, such differences were not evaluated statistically. For example, in a study by Riecher-Rossler and Hafner (2000), results showed that women seemed to have a more favorable course and a better psychosocial outcome than men. Hospital stays were fewer and shorter and their psychosocial adjustment and living situation better than those of men. Other studies have also consistently shown a higher age of onset in women than in men. The average differences of 3.5 to 6 years is evident at the first onset of early symptoms of the illness and has been found in almost all cultures investigated (Hafner et al., 1993; Jablensky et al., 1992; Sartorius et al., 1986).

A related limitation of this study is that it did not investigate other variables, which could potentially predict need for inpatient care. Because only approximately 8% of the variance in clinicians’ level of care decisions were accounted for by clients’ degree of insight, clearly other factors are important to the clinical decision-making process. According to Cohen (1992) the results indicate a small effect size, yet a significant one. While insight plays a role in predicting inpatient status, other variables must also be
considered. Variables such as degree of suicidiality, homicidality, severity of symptoms, and psychosocial functioning should also be examined to determine how much they account for in variance of inpatient admission. Future research that includes these factors and other variables would help clinicians have a better understanding of what variables to assess, and their impact in making level of care determinations.

Limitations are also noted regarding the instruments utilized in this study. The scale used to measure degree of insight, the SUMD (Amador & Strauss, 1993) is a 20-item instrument. In this study, only three global insight items were used because these are the major subscales the instrument is based on. The other items address 17 areas of symptom-specific insight, and therefore, were not used in this study. If the additional 17 items had been used, that may have revealed more about symptom-specific insight shedding more light upon insight specificity, rather than more broadly as did the three global subscales. The FARS (Ward & Dow, 1994) was used to assess current need for inpatient admission. Only one item from the scale was used to assess this variable. Utilizing only one item may have limited validity in relation to current need for inpatient admission. However, to date, there is no scale to measure current need for inpatient admission. A decision to admit a client for inpatient treatment is usually made by a licensed professional, who assesses the need for a more restrictive level of care by asking questions to elicit whether or not harm to self or others is present. Therefore, while only one scale on the FARS (Ward & Dow, 1994) was used to assess current need for inpatient admission, it still remains a quantitative, objective measure rather than a subjective one, as currently employed by licensed clinicians making determinations for inpatient care. Certainly this brings to light the need for more objective and quantitative
measures to assess need for inpatient care. Currently, the decision to hospitalize lies in
the hands of licensed clinicians, whose decisions are made rather subjectively. This
heightens the need of licensed clinicians making these determinations to be trained
thoroughly in assessment and appropriate clinical judgment to recognize when clients
need a higher level of care. Future research should focus efforts on developing objective,
reliable measures that clinicians can use to make decisions for inpatient care.

Another issue related to the ‘need for inpatient admission’ item on the FARS
(Ward & Dow, 1994) is how this item was operationalized. This item was behaviorally
defined as clients who needed suicide watch, locked unit, behavioral contract, protection
from others, involuntary exam/commitment, and seclusion due to extreme distress and/or
psychosocial impairment. While these behavioral items often necessitate the need for a
higher level of care (i.e., hospitalization) they are broad and can be rather subjective
based on the clinician’s interpretation. Although data show that good reliability has been
reported (e.g., Schwartz, 1999b), perhaps the inclusion of standardized and more
objective questions would minimize subjective interpretation and thus further increase
item reliability.

Multicultural competencies among clinicians may also be a potential limitation to
consider. Although no evidence is apparent suggesting a lack of multicultural
competence among clinicians, all clinicians graduated from a CACREP (2001) accredited
program and were trained in assessing mental disorders; it is important that clinicians,
conducting assessments specifically on psychotic clients, take culture into account before
making treatment-related decisions. Beliefs that appear to be delusional in one culture
(e.g., sorcery and witchcraft) may be commonly held and sanction perceptions in another
culture. This is especially true for visual and auditory hallucinations with religious content which may be a normal part of a religious experience in other cultures (APA, 2000). Therefore, it is important to consider the cultural reference point and multicultural skills of the clinicians, who conducted the assessments, versus the cultural reference of the clients in the sample. This factor was not taken into account in this study.

Currently, there is a small body of research assessing the impact of social factors, such as culture and ethnicity, on insight in psychosis. Johnson and Orrell (1995) have challenged the widely acceptable position that insight reflects awareness of illness and adherence to psychiatric treatment. They suggest that because the stigma of mental illness is harsh in many societies, individuals with psychosis may deny the full extent of their symptoms, in order to preserve their social status and relationships in the community. Differing ethnic groups or cultures may also have fundamentally different views on mental health treatment and medications, therefore discouraging individuals from being forthcoming with symptoms or accepting help (i.e., psychiatric treatment). These groups may have realistic fears of being viewed as “abnormal” or “deviant.”

Although this research study did not examine how culture affected diagnoses or level of care decisions, recent studies have investigated this phenomenon. One study, in particular, found that professional counselors evidenced disproportionate psychotic disorder diagnoses among African-American versus Euro-American clients (Schwartz & Feisthamel, in press). Studies such as these suggest that clinical perceptions and measures of insight may introduce biases when assessing clients, who are culturally different, from that of the clinician (Feisthamel & Schwartz, 2006). Development of
more comprehensive and culturally sensitive models of insight and psychosis, ones that attempt to understand clients’ illness experience in a cultural context, are needed.

Summary of Discussion and Implications

This study investigated whether insight among psychotic clients impacted level of care and treatment-related decisions among professional counselors. Specifically, the study examined whether insight among psychotic clients differed in clients in an outpatient treatment setting versus inpatient treatment, and whether degree of insight related to current need for inpatient admissions. The results of this study showed that there was a statistically significant difference in insight, as measured by the SUMD (Amador & Strauss, 1993), between inpatient and outpatient levels of care among clients diagnosed with psychotic disorders. Furthermore, degree of insight (specifically poor insight into the need for treatment) significantly predicted current need for inpatient admission. These results are consistent with related previous studies, which found relationships between degree of insight and levels of care. These findings support previous research that less insight is related to increased levels of care (i.e., inpatient admissions and re-admissions). The results were compared with those from previous research studies, in this area, and implications for clinical practice and Counselor Education were offered. Finally, limitations and implications for future research were discussed, including recommendations for a more diverse sample population to expand generalizability, examining demographic between-group differences that may have influenced the results, expanding insight items of the SUMD to incorporate symptom-specific insight, creating more objective measures to assess current need for inpatient
admission, and considering cultural factors that could potentially psychotic disorder diagnoses and the measurement of insight.
REFERENCES


Lysaker, P. H., Bell, M. D., Bryson, G. J., & Kaplan, E. (1998). Insight and interpersonal function in schizophrenia. *Journal of Nervous and Mental Disease, 186*, 432-436.


APPENDIX

INSTITUTIONAL REVIEW BOARD FORM

The University of Akron Institutional Review Board

Registration Form

Please complete this form if you propose to conduct a project that involves collecting information about human individuals that meets one or more of the criteria below:

TRB review is not required because:

☐ This project does not meet the Common Rule definition of research.
☐ All data/associates are about those deceased individuals.
☐ Results will be shared only with the client or stakeholder(s) for private use for evaluation or educational/decisional purposes or for other non-research purposes.
☐ This project is not only data from secondary sources that are not individually identifiable.
☐ This project is an internal evaluation (audited or quality control of ongoing program).
☐ The project involves only study and practice interventions, such as open record interventions, that (1) do not document specific events or the experiences of individuals without intent to draw conclusions, generalize findings, or influence policy or practice.

Project Title: [The Relationship between Degree of Insight into Illness and Level of Care Among Clients with Psychotic Disorders]

Principal Investigator (PI): Hindi Buffone-Brown, MA, LPC

PI Department: Department of Counseling

PI Phone: [530] 429-4945

Co-investigator(s) (list all co-investigators)

Faculty Advisor (if PI is a student): Dr. Robert Schwartz

Provide below a brief description of the purpose of this study and the type and source of this information on human individuals that will be collected. (The space will expand as you type.)

This project is being conducted for a doctoral dissertation. The purpose of the study is to investigate how insight among psychotic clients relates to level of care. Specifically, it will be evaluated in terms of (1) willingness of clients to accept treatment, (2) engagement in treatment, and (3) level of functioning. Data will be collected from community mental health agencies in a southeastern state. Data will include medical, demographic, and diagnostic information. In addition to quantitative data related to a client's score on measures of insight and support from the project advisor. All data have been previously collected, and have been previously approved by the University of Akron IRB. No new data will be collected, and no identifying information is included in the obtained data that will be statistically analyzed.

Investigator's Assurance

I certify that the information provided in this Registration Form is complete and accurate. I understand that as Principal Investigator, I have ultimate responsibility for the ethical conduct of this project.

Principal Investigator: ___________________________ Date: 10/11/07

Faculty Advisor's Assurance

I certify that the student is knowledgeable about the regulations and policies governing the research and has sufficient training and experience to conduct the proposed study.

Faculty Advisor: ___________________________ Date: 10/11/07

Please submit this form to the IRB, c/o ORSSC, 384 Eubanks, 44325-2192

Examiner: ___________________________ Date: 10/11/07

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