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BRIEF REPORT

Insight as a Dual-Perspective Construct: Convergence Between Patients' and Professional Evaluators' Perspective on Baseline Level of Insight and on Changes in Insight

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Insight gained by patients during treatment has been theorized to be a central mechanism of change in psychotherapy, but empirical studies examining the association between patients' insight and psychopathological symptoms have produced mixed results. The present study addresses these inconsistencies by investigating convergence between the perspectives of patient and professional evaluator on insight and disentangling two potentially distinct components of insight: pretreatment individual differences and changes in insight during treatment. A sample of 393 patients receiving psychodynamic psychotherapy completed pre- and posttreatment measures on symptoms and insight. Professional evaluators evaluated patients' insight based on clinical interviews pre- and posttreatment. Polynomial regression and response surface analyses were used to examine congruence. The results indicate that when there was agreement between the patient and the evaluator on insight, both baseline level of insight and the changes in insight during treatment were found to be related to symptomatic change, although showing different patterns of association. Lower baseline levels of insight were significantly associated with greater symptomatic improvement than were higher levels of insight. At the same time, greater increase in insight during treatment was moderately significantly associated with greater reduction in symptoms, as long as the changes in insight were not minimal. The findings underscore the importance of assessing the congruence between patients' and professional observers' perspectives on patient insight and the potentially distinct roles of between-patients baseline differences and within-patient changes in insight during treatment.




Clinical Impact Statement

Question: What is the applied clinical practice question this article is hoping to address? Does the clinician–patient agreement regarding the patient's level of insight and regarding the changes in insight over the course of treatment predict the severity of the patient's psychopathology or treatment outcome?

Findings: How would clinicians meaningfully use the primary findings of this article in their applied practice? In situations of clinician–patient agreement regarding the patient's level of insight and the changes in insight over the course of treatment, the level of insight has a predictive effect on the severity of the patient's psychopathology and on treatment outcome. **Meaning:** What are the key conclusions and implications for future clinical practice and research? Agreement between patients and clinicians on the patient's level of insight is of clinical importance. **Next Steps:** Based on the primary findings and limitations of this article, what are future directions to be explored in clinical practice and research? The patient's level of insight should be assessed as a dyadic construct, capturing a more dependable measure of insight than of either their evaluations.

Keywords: insight, psychodynamic treatment, psychodynamic mechanism of change

Supplemental materials: <https://doi.org/10.1037/pst0000345.supp>

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Gaining insight is a central mechanism of therapeutic change which was reflected by Freud's (1933/1964, p. 80) seminal idea of "where the id was, there ego shall be", which meant that curing neurotic symptoms could be achieved by awareness of repressed memories. A modern definition of insight (also known as self-understanding) was suggested by Jennissen et al. (2018) as "patients' understanding of associations between past and present experiences, typical relationship patterns, and the relation between interpersonal challenges, emotional experience, and psychological symptoms" (p. 966). It is possible to consider insight in terms of process, state, and ability to achieve a new understanding (Gibbons et al., 2007; Hill et al., 2007).

Individual differences in insight are conceptually related to individual differences in the severity of patients' symptoms, such as patients with good insight are expected to show flexibility in responsiveness while dealing with conflicts, and therefore present fewer symptoms (Freud, 1958). Gaining insight is beneficial because it may enhance the sense of control through the formation of understanding about the origins of the symptoms (Jennissen et al., 2018). Although insight has different meanings in different psychotherapy traditions, it was suggested that it is a *common factor* that contributes to success in different types of psychotherapy orientations, including cognitive-behavioral therapies (Wampold et al., 2007).

A recently published meta-analysis indicated that the associations between patient's insight and treatment outcome have a moderate-sized effect. This correlation is notable, as the effect size is similar to other important established treatment factors, such as therapeutic alliance (Jennissen et al., 2018). However, results from empirical studies on insight shows mixed results. Although some have demonstrated a significant association between insight and symptoms, others failed to find any significant association (Gibbons et al., 2007).

We propose that two factors may have contributed to the mixed results in previous studies:

- (a) Heterogeneity in the perspective of the methods of measuring insight: In some studies, insight was measured from the perspective of an external evaluator or of the therapist (Høglend et al., 1994; Kallestad et al., 2010; Kivlighan et al., 2000; Levy et al., 2015), whereas in others, it was based on the patient's self-report (Gibbons et al., 2009, 2015).
- (b) Previous studies investigated insight as one construct, without distinction between two aspects: baseline level of insight and changes in insight level. It has been previously suggested that not separating these two aspects can lead to mistaken conclusions and mixed results (Kraemer et al., 2002).

With respect to the first factor of heterogeneity in the perspective of measuring insight, Hill et al., (2007) proposed to combine different methodologies to overcome the biases of each methodology and to achieve a more adequate measure of insight. Following Hill et al. (2007), we suggest that a more dependable measure of insight may rest on the agreement between distinct evaluators of insight. The first perspective is the patients' self-report of their own level of insight that represents the extent to which they

believe that they understand what affects their behavior in the world. In contrast, the second perspective, that of the professional evaluator, represents a professional's perception of the patient's level of insight. This perception may be affected by what the professional knows, as well as what he does not know, about the patient, but may also reflect a professional evaluation and knowledge of insight that the patient does not have. Such "dual perspective on insight," may reflect the convergence between the patient's and the external professional evaluator's perspectives when judging the patient's insight level.

With respect to the second factor, whereas previous studies commonly measured insight in either baseline assessment or as changes during treatment, the literature suggests that focusing on the baseline level of a construct (stable individual differences between patients) is not the same as focusing on the changes that occur in a construct during treatment (Kraemer et al., 2002). Each may play a different role in treatment process and outcome. Such a distinction may be critical in studying insight as well, with the baseline levels of insight referring to differences between various patients before the start of treatment, and changes in insight referring to the extent to which the patients gained (or lost) insight over the course of treatment.

The present study seeks to expand the understanding of insight and outcome by investigating it as a dual-perspective construct and by disentangling its two aspects (baseline level and changes in insight during treatment). Although no study to date has disentangled the two aspects of insight, it is possible to identify specific studies that focused on one of the aspects solely and showed different results.

In regard to *baseline level of insight*, most of the previous studies indicated that baseline insight did not predict improvement in symptom severity as the outcome measure (Gibbons et al., 2015; Kallestad et al., 2010; Levy et al., 2015), although not without exceptions (Hoffart et al., 2002). In regard to studies that investigated *changes in insight*, Kivlighan et al. (2000) indicated that increases in a patient's insight at one session are followed by lower target complaint ratings at the following session. In addition, Gibbons et al. (2009) demonstrated that change in insight from intake to termination was related to improvement in specific outcome measures, such as depression, but not to others, such as anxiety. Høglend et al. (1994) showed that the change in insight between intake and 2-year follow-up predicted an improvement in symptoms at a 4-year follow-up. Taken together, most of the previous studies indicate that baseline level of insight does not appear to be a consistent predictor of symptoms, whereas the change in insight has been shown to be a relatively consistent predictor.

In the present study, we focus on insight as a dual-perspective construct, disentangling its baseline and change aspects. To produce a more dependable measure of insight, one of the most commonly used methods for testing agreement was chosen, that is, the response surface analysis (Shanock et al., 2010), which refers to both agreement and disagreement between distinct evaluators of insight. Our hypotheses in relation to agreement are as follows:

Hypothesis 1: Baseline insight and pretreatment symptoms: Although it is yet to be systematically examined directly in previous studies, based on the theoretical literature (Freud, 1958), we hypothesize a negative association between the dual

perspective of the baseline patient's level of insight and patient's level of symptoms. Specifically, in cases when patients and professional evaluators agree on lower levels of insight at intake, patients will report higher levels of symptoms at intake.

Hypothesis 2: Baseline insight and changes in symptoms: Given that the baseline level of insight has not been found in most previous studies to predict the changes in treatment outcome throughout the course of therapy, we do not expect to find significant differences in improvement in symptoms in the course of treatment when professional evaluators and patients agree on a higher or lower level of insight at intake. This question was considered exploratory, as no study to date directly examined this question with a dual perspective measure of insight and given that conceptually it is possible to assume that higher initial levels of insight are expected to be associated with better treatment outcome, which is consistent with the findings of Hoffart et al. (2002).

Hypothesis 3: Change in insight and changes in symptoms: We expect to find that, when the patients and professional evaluators agree on higher gains in insight, the improvement in symptoms during treatment will be significantly higher than when patients and professional evaluators agree on lower gains in insight. Because the size of the available sample was insufficient to test this hypothesis, it was considered exploratory.

Given the fact that no study to date examined insight as a dual-perspective construct, we cannot formulate any hypotheses on the effects of disagreement between patients and professional evaluators, and this part of the study is exploratory.

Method

Participants

Patients

The final sample included 393 participants who sought treatment at the university counseling center during the period 2003 to 2005. Seventy percent of the patients were undergraduate students, 20.4% were graduate students, and 9.1% doctoral students or university staff. All patients agreed to participate in the study and signed an informed consent form. Anonymity was guaranteed, and the study was approved by the ethical review board. There are currently no prior studies with the same data set. Further information regarding patients' demographic characteristics and inclusion criteria is given in the online supplemental materials.

Professional Evaluators

The professional evaluators were interns or licensed clinical psychologists, who were responsible for assessing the patient's level of insight. They all had at least 2 years of experience in therapy, with a psychodynamic orientation. All received professional training focusing on evaluating the patient's level of insight. Further information regarding the professional evaluators is detailed in the online supplemental materials.

Therapy and Therapists

All patients were assigned to psychodynamic psychotherapy. The length of treatment was generally 1 academic year. The therapists included clinical social workers, interns and licensed clinical psychologists.

Measures

Demographic Characteristics

Patients were asked to provide demographic data in the questionnaire administered at the intake session, including gender, education, minority group membership, marital status, and employment status.

Psychopathological Symptoms

Symptom level was assessed using a self-report questionnaire: the revised version of the ComPASS (formerly called the Integra Outpatient Treatment Assessment system questionnaire; Lueger, 2012). The questionnaire includes 33 items scored on a 6-point Likert scale (1 = *not at all* to 6 = *very much*). The questions survey a variety of symptoms associated with anxiety, depression, psychosis, substance abuse, and more. A previous version of the questionnaire showed high internal reliability (0.95), good test-retest reliability (0.85), and a high correlation (0.91) with an abbreviated 47-item version of the Symptom Checklist-90 (Derogatis & Cleary, 1977; Lueger et al., 2001). The questionnaire was translated into Hebrew and showed good internal reliability in the present study (Cronbach's $\alpha = .92$).

Insight Based on Patient's Perspective

Patient's insight level was assessed using a single-question measure scored on a 5-point Likert scale (1 = *not at all* to 5 = *very much*) answered by the patient. The instruction was "Try to define how well you understand yourself."

Insight Based on Professional Evaluator's Perspective

The professional evaluators assessed the patient's level of insight using a single-question measure scored on a 5-point Likert scale (1 = *not at all* to 5 = *very much*). The question was "To what extent does the patient show ability for self-understanding?" The question was worded using the term "self-understanding," which is used interchangeably with the term "insight" (Gibbons et al., 2007). The Hebrew wording of the term "self-understanding" presented to the professional evaluator was slightly different from the term presented to the patient in order to match their different backgrounds (education, experience, etc.). The assessment was carried out by an intern or a licensed clinical psychologist, who conducted an interview of 1.5 hr with patients. Information regarding evaluators' training, the evaluation process and the measure's reliability are presented in the online supplemental materials.

Procedure

The present study is based on data collected between 2003 and 2005 from a university counseling center in Israel. There are no prior studies with the same data set. Evaluation and data collection were conducted before treatment and at the termination phase.

Patients were asked to complete the pretreatment questionnaire before the intake session. Next, patients were scheduled for an intake session. Every applicant who gave consent to use their personal data for research purpose was automatically included in the study group. On the basis of the intake session, the professional evaluator made the evaluation of the insight level. After the intake, the patient was assigned to therapy. About three to four months after the end of treatment, a random sample of patients was offered to participate in the follow-up part of the study, and they received an evaluation questionnaire by mail. Overall, 98 patients responded to the follow-up questionnaire (about 70% of those who were approached). Of these, 36 patients who expressed interest were also invited to participate in a follow-up interview with an independent clinician. At the end of the interview, the professional evaluator rated the patient's level of insight.

Data Analysis

To examine our hypotheses, we conducted a response surface analysis by polynomial regression (Shanock et al., 2010). This statistical method was introduced to the field of counseling and psychotherapy research by Marmarosh and Kivlighan (2012) and since then has been used in more than a dozen psychotherapy research studies. We used this method to investigate trends in situations of agreement and disagreement between patients and professional evaluators in their perceptions of patient's insight. The statistical method is described here succinctly and is fully described in the online supplemental materials.

The following regression equations were used:

Research Question 1: Baseline insight and pretreatment symptoms:

$$SY = b_0 + b_1PA + b_2PE + b_3PA^2 + b_4PA \times PE + b_5PE^2 + e,$$

Research Question 2: Baseline insight and changes in symptoms:

$$\Delta SY = b_0 + b_1PA + b_2PE + b_3PA^2 + b_4PA \times PE + b_5PE^2 + e,$$

Research Question 3: Changes in insight and changes in symptoms:

Step 1:

$$\Delta SY = b_0 + b_1PA + b_2PE + e,$$

Step 2:

$$\Delta SY = b_0 + b_1PA + b_2PE + b_3(\Delta PA) + b_4(\Delta PE) + b_5(\Delta PA)^2 + b_6(\Delta PA) \times \Delta PE + b_7(\Delta PE)^2 + e,$$

where PA represents the patient's insight rating; PE, the professional evaluator's insight rating; SY, the patient's symptoms; and Δ , the change in the variable from the beginning of treatment to its termination point.

Results

A description of the preliminary analysis, the missing data management and the post hoc analysis is attached in the online supplemental materials.

Baseline Insight and Pretreatment Symptoms

We used the first polynomial regression model to test the relationship between the patient's insight levels and their psychopathological symptoms at intake. We found that the five insight agreement variables accounted for 18.2% of the variance in the patient's symptomatic level at the beginning of treatment, $F(5, 391) = 14.12, p > .001$. As shown in Table A2 (all the tables are presented in Appendix A in the online supplemental materials), the patient's and the professional evaluator's perspectives on the patient's insight level were negatively related to the patient's symptomatic level at the beginning of treatment ($B = -0.40, SE = 0.06, t(391) = -6.66, p < .001$) and ($B = -0.18, SE = 0.08, t(391) = -2.36, p = .02$), respectively. In addition, the square of the patient's and of the professional evaluator's perspectives of the patient's insight level were positively related to the patient's symptomatic level at the beginning of treatment $B = 0.17, SE = 0.04, t(391) = 4.46, p < .001$ and $B = 0.18, SE = 0.06, t(391) = 2.79, p = .006$, respectively. These results indicate that the perspectives of the patient and of the professional evaluator were significant predictors of the severity of symptoms, but not so the interaction of their perspectives.

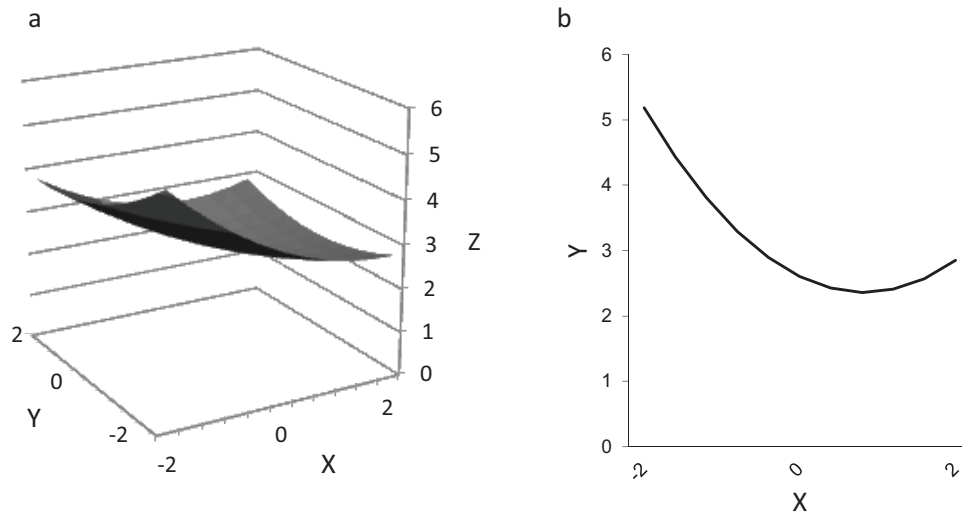
To characterize trends in situations of agreement and disagreement between patients and professional evaluators, we examined the linear combinations of effects, following Shanock et al. (2010) recommendations. The results of this analysis are shown in Figure 1, below. The significant negative slope along the line of agreement ($a_1 = -0.58, p < .001$), which is shown in Table A3, suggests that in situations in which patients and professional evaluators agreed on the patient's insight level, higher levels of insight were correlated with less severe psychopathological symptoms. This result is consistent with hypothesis 1. At the same time, the significant positive curvature along the line of agreement ($a_2 = 0.35, p < .001$) suggests that, although at baseline the psychopathological symptoms decrease as insight levels increase, at very high levels of insight, the direction of the slope changes, and the levels of symptoms increase (Figure 1[b]).

The significant negative slope along the line of disagreement ($a_3 = -0.22, p = .02$) suggests that situations of disagreement between professional evaluators and patients were associated with the severity of symptoms. Disagreement can be expressed in two ways: the professional evaluator may think that the insight is low while the patient thinks it is high, or vice versa. The results suggest that the psychopathological symptoms were less severe when the professional evaluator thought that the patient's insight level was low while the patients thought that their insight level was high, than when the situation was reversed (Figure 1).

Baseline Insight and Changes in Symptoms

Our second research question addresses the ability of the patient's initial levels of insight to predict symptomatic improvement. We found that the five insight agreement variables accounted for 10% of the variance in symptomatic improvement, $F(5, 89) = 2.98, p = .02$. As shown in Table A4 in the online supplemental materials, the patients' perspective of their own insight level was negatively related to their symptomatic improvement, $B = -0.43, SE = 0.13, t(89) = -3.23, p = .002$. Moreover, the square of the patients' perspective on their own insight level was positively related to their symptomatic improvement,

Figure 1
Patient's and Professional Evaluator's Perspective on the Patient's Level of Insight and Patient's Pretreatment Symptoms



Note. In (a) the x axis is the patient's perspective on his initial level of insight (centered), the y axis is the professional evaluator's perspective on the patient's initial level of insight (centered), and the z axis is the pretreatment symptoms. In (b) the x axis is the patient's initial insight (given agreement between patient's and professional evaluator's insight ratings) and the y axis is the pretreatment symptoms.

$B = 0.20$, $SE = 0.09$, $t(89) = 2.35$, $p = .02$. These results suggest that the patients' perspective on their own initial level of insight is related to the change in symptoms, but not the professional evaluator's perspective or the interaction of the perspectives of the two.

The significant slope and curvature along the line of agreement ($a_1 = -0.49$, $p = .002$, $a_2 = 0.29$, $p = .04$), as shown in Table A3 in the online supplemental materials, suggests that the agreement between patient and professional evaluator on higher levels of insight at baseline was significantly associated with less improvement in symptoms. The direction of the association is not consistent with our hypothesis. Nevertheless, when there was agreement on relatively high levels of initial insight ratings, symptomatic improvement increased as the insight ratings increased, consistent with our hypothesis (Figure B1 in the online supplemental materials).

Changes in Insight and Changes in Symptoms

We used the third polynomial regression model to test whether improvement in insight is related to symptomatic improvement, while controlling for the initial insight levels. The five insight agreement variables approached a level of significance and accounted for 8.8% of the variance in the symptomatic improvement, $F_{Change}(5, 25) = 2.21$, $p = .085$. As shown in Table A5 in the online supplemental materials, the interaction between the patient's and professional evaluator's perspectives on the change in the patient's insight level correlated positively with symptomatic improvement, $B = 0.439$, $SE = 0.257$, $t(25) = 2.09$, $p = .047$. The results indicate that the interaction of the perspectives of the professional evaluator and the patient, but not the perspective of each one by itself, explains the change in symptoms.

As shown in Table A3 in the online supplemental materials, the slope along the line of agreement was not significant ($a_1 = -0.26$, $p = .54$), suggesting that when patients and professional evaluators agree on the extent of the change in insight during therapy, there was no linear correlation between the degree of change in insight and symptomatic improvement. The significant curvature along the line of agreement ($a_2 = 1.18$, $p = .01$), however, suggests that for patients who gain relatively high levels of insight, the more insight they gained, the more their symptoms improved during treatment. This result is consistent with our hypothesis. At the same time, for patients who gained relatively low levels of insight, the more insight they gained, the less their symptoms improved during treatment (Figure B2[b] in the online supplemental materials).

Discussion

Insight is a central concept in psychotherapy, and it is theorized to play a critical role in the process of change in psychodynamic theories. The present study sought to explore patient's insight level as a dual-perspective construct, looking at agreement between the patient's and professional evaluator's perspective regarding the patient's insight. We focused on two aspects of the construct of insight and examined their associations with pretreatment symptoms and symptomatic change.

Our first research hypothesis deals with the association between the patient's baseline level of insight and pretreatment symptoms. In accordance with our assumptions, agreement on low levels of baseline insight were found to be significantly associated with higher levels of symptoms. This finding may support Freud's (1958) classical argument, according to which psychopathological

symptoms occur as a result of patients enacting the contents of their unconscious mind due to the lack of insight. At the same time, contrary to our expectations, agreement on very high levels of insight was also associated with reports of more severe symptoms. One possible post hoc explanation of this finding is that extremely high levels of insight in individuals seeking treatment demonstrate situations in which deep insight is connected with a painful preoccupation with oneself or with rumination (Lyubomirsky, 2001).

Our second hypothesis deals with the association between baseline levels of insight and change in symptoms during treatment. The findings suggest that agreement on low levels of baseline insight was significantly associated with greater improvement in symptoms. These findings are not consistent with our hypothesis. One post hoc explanation is that gaining insight is especially beneficial for patients who demonstrate poor levels of insight before the start of treatment. In such cases, the treatment may focus on improving the patient's deficits (Barber & Muenz, 1996). Most previous studies failed to find such a direct relationship (Gibbons et al., 2007; Grande et al., 2003; Høglend et al., 1994; Kallestad et al., 2010). In contrast to the present study, however, the vast majority of these studies did not assess the patient's perspective on their level of insight but focused exclusively on the therapist's or the professional evaluator's perspective. At the same time, our results also indicate that agreement on particularly high initial levels of insight correlate with a good outcome. One post hoc explanation of such findings relates to the theory of capitalizing on strengths (Cheavens et al., 2012), according to which patients may benefit most when the treatment focuses on their greatest strengths.

Our third research hypothesis deals with the relationship between the changes in insight during treatment and change in symptoms. The analysis yielded nonsignificant results, although they approached significance, and the effects were relatively large. The direction of the moderately significant findings is in accordance with our hypothesis: agreement on gaining a notable amount of insight during treatment was associated with a marked improvement in symptoms. This finding is in line with the long-standing claim that insight gain is an important mechanism of change in dynamic psychotherapy. When the patients' conscious self-knowledge is expanded, they are expected to gain better control over their mental functioning (Shapiro, 2009; Sugarman, 2006). The findings are also consistent with previous ones, summarized in a recent meta-analysis (Jennissen et al., 2018) suggesting that upon gaining insight, patients may create associations between existing psychological problems and past experiences and might see their contribution to the reappearance of these experiences. In addition, gaining insight might help reduce distorted perceptions of oneself and others and improve integration of unpleasant experiences.

Surprisingly, findings further suggest that patients who have hardly acquired any insight at all during treatment also showed much improvement in symptoms. One potential post hoc explanation is that the therapists may have understood that gaining insight during treatment was not applicable or beneficial for these patients, for a variety of reasons, and therefore the therapists may have responded to the patient's needs (Stiles, 2013) by not focusing the treatment on improving insight. Thus, other active components, such as supportive elements, could have improved symptoms, for example, through the formation of a corrective experience (Cas-

tonguy & Hill, 2012; Leibovich et al., 2018). Taken together, the results indicate that both baseline level of insight and the change in insight were found to be related to symptomatic change, and showed distinct patterns of associations.

The exploratory research questions regarding patient-professional evaluator disagreement hardly yielded significant results. Given the fact that no study to date examined disagreement between patients and professional evaluator regarding patient's insight, further research is required to fully understand the results. The one significant result found regarding the level of disagreement indicates that, when patients thought that their insight was high (and the professional evaluator thought that the insight was low), their pretreatment symptoms were relatively low, compared to the opposite type of disagreement. In the case that this result will be replicated in future research, it will stress the importance of referring to the patient's subjective experience and to validating the patient's point of view, rather than trying to convince him or her otherwise. Affirmation is considered a supportive intervention that has been shown to have beneficial effects (Safran et al., 2011).

The main limitation of the study lies in the small sample size, especially for Hypothesis 3. This makes the current findings an important starting point for future investigation, rather than the basis for definite conclusions. Another limitation has to do with the measurement tools we used. The fact that the study relied on self-report questionnaires and used single-item measures for insight limits the generalizability of the findings, although it may accurately reflect the way such evaluations are often conducted in naturalistic settings. Furthermore, as is often the case in naturalistic settings, the two professional evaluations of insight (pre- and posttreatment) were not necessarily conducted by the same evaluator, and given the ways the data were collected, we were not able to account for therapist's and evaluator's effects. Additional limitations include the low number of minority individuals in the subsamples that went through the posttreatment assessments (as found in the preliminary analyses, detailed in the online supplemental materials).

The results of our study underscore the importance of assessing the different perspectives of the patient and of a professional evaluator. Measuring insight from these perspectives, while differentiating between baseline individual differences and changes in insight during treatment appears to make possible the discovery of new paths of inquiry about the roles of insight in treatment, which would not be visible based on the separate perspectives of the patients or of the professional evaluators.

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