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BRIEF REPORT

The Development of a Comprehensive Coding System for Evaluating Insight Based on a Clinical Interview: The SUIP-I Coding System

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Gaining insight is considered a cornerstone of psychodynamic psychotherapy. Existing tools used to measure insight mainly include patients' self-report questionnaires and external coding of therapy sessions. To expand on the available tools, the present study developed a comprehensive coding system for the Self-Understanding of Interpersonal Patterns Scales–Interview (SUIP-I; Gibbons & Crits-Christoph, 2017). A total of 55 patients enrolled in a randomized controlled trial received psychodynamic psychotherapy for depression and were interviewed using the SUIP-I at baseline. A comprehensive coding system was developed for rating the interviews, based on a Likert scale for each of the six levels of insight. The content validity, psychometric properties, and the reliability and validity of the coding system were examined. The new SUIP-I coding system demonstrated interrater reliability in the "excellent" range, ICC (1, 1) = .91–.97, for all the six levels, and adequate internal consistency (Cronbach's $\alpha = .81$). Support for convergent validity was gained, as manifested in a significant positive association of the SUIP-I with alliance expectation and affiliation, and a significant negative association with avoidance attachment. Support for discriminant validity was also gained, as manifested in a weak, nonsignificant association between the SUIP-I and self-esteem. The proposed comprehensive coding system shows good initial reliability and validity. Research is needed to further establish the psychometric properties of the new SUIP-I coding system.

Clinical Impact Statement

Question: Can a coding system be developed, based on a Likert-scale, for the Self-Understanding of Interpersonal Patterns Scales–Interview such that it can represent a systematic assessment of insight? ***Findings:*** The developed Likert-scale-based systematic coding system can be used by clinicians to evaluate the level of insight. ***Meaning:*** Insight can be reliably quantified as a continuous range based on a semistructured interview. ***Next Steps:*** After further validation of the SUIP-I coding system, it can be used to create an understanding of differences in level of insight between individuals, as well as changes within individuals throughout treatment.

Keywords: insight, self-understanding, core conflictual relationship theme, psychodynamic treatment, process research

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Gaining insight is a central mechanism of therapeutic change and is considered a cornerstone and an integral component of psychodynamic psychotherapy (Barber et al., 2013; Messer & McWilliams, 2007). Insight may be defined as a conscious event of a shift in meaning (Hill et al., 2007) that patients achieve by making associations between aspects of past and present experiences, typical relationship patterns, and the relation between interpersonal challenges, emotional experience, and psychological symptoms (Jennissen et al., 2018).

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A recently published meta-analysis that systematically examined the association between insight and psychotherapy outcome found a moderate-sized effect. However, there was significant heterogeneity across studies (Jennissen et al., 2018), which can potentially be explained, among other reasons, by the diversity of methods for assessing insight.

Methods of insight evaluation include patients' self-report questionnaires and external clinician-rated insight scales based on various sources, such as session content. Although there are advantages to using self-report questionnaires, especially the simplicity of administration, they may also be biased due to participants' tendency to present a favorable image of themselves as part of the social desirability phenomenon (Van de Mortel, 2008). Methods based on narrative materials, such as session content, have benefits as they are based on existing sources, which makes it viable to sample insight levels at multiple time points throughout treatment. However, these measures also have disadvantages, as they are based on utilizing sources of information not necessarily designed to assess insight capacity, and therefore, may produce variability that relates to other contexts (e.g., therapist interventions).

To overcome the above-mentioned shortcomings of the available measures of insight, a preliminary version was developed of the Self-Understanding of Interpersonal Patterns Scales–Interview (SUIP-I; Gibbons & Crits-Christoph, 2017). This preliminary version of the SUIP-I is a semistructured interview conducted with patients in order to assess their insight level. Since this is the first article on this interview, the full interview appears in the Supplemental Material. The SUIP-I is based on the Core Conflictual Relationship Theme framework (Luborsky, 1977), which consists of three components: (a) the patient's wish (W) in the context of a relationship; (b) an actual or anticipated response from that other (RO) in the context of this wish; and (c) a subsequent response from the self (RS; Book, 1998). To the best of our knowledge, to date, the SUIP-I is the only semistructured interview that measures patients' insight directly by asking insight-related questions and thus it is less prone to the bias of task irrelevancy. In the SUIP-I, patients are asked to share five stories about relational exchanges with significant others which they see as problematic. Structured questions are used to give the patients the opportunity to verbalize their understanding of each interaction without leading them. The interviewer evaluates their ability to recognize, understand, and describe their conflictual pattern. The SUIP-I is based on indirect questions to evaluate insight instead of direct explicit questions (e.g., "rate your insight level"). Therefore, the interviewer can obtain data that goes beyond what the individual is capable, aware of, and interested in disclosing in order to evaluate the individual level of insight. For example, the patients might answer that they recognize that the pattern is replicated with different people, but in their answer, they are able to refer only to one component of the pattern, rather than all three components (W, RO, RS). Therefore, although they answer positively in relation to the question, their answer indicates a low level of insight. Thus, the SUIP-I has the potential to be less prone to the bias of social desirability that can influence the measurement of insight.

Insight is conceptualized by the SUIP-I as a holistic multidimensional concept, addressed by six different levels coded by the interviewer. In the original SUIP-I, the coding was binary for each of the six levels in each story. An unpublished pilot study suggests that, although the SUIP-I has strong content validity, yielded important data during the interview and was well-accepted, its coding system lacked sensitivity in identifying differences in insight between individuals (Yaffe-Herbst, 2019). Therefore, the overarching goal of the present study was to develop an adapted coding system for the SUIP-I by expanding the original binary coding method. This was accomplished through developing a Likert scale for each of the six levels. This article describes four subgoals used to achieve this goal.

First, to establish content validity, we incorporated a theoretical basis regarding insight by consulting experts in the field and by reviewing the conducted interviews themselves. Second, we evaluated the descriptive statistics of the new measure. Due to the nature of the clinical population, individuals with depressive symptoms seeking treatment, we hypothesize that the baseline insight level will be relatively low and have an asymmetric distribution. Third, we examined the internal reliability and interrater reliability of each level. We hypothesized a high level of reliability (Portney & Watkins, 2009). Fourth, we examined convergent and discriminant validity. For convergent validity, we examined the association between the SUIP-I and other baseline measures that are theoretically related to insight. We expected them to support convergent validity as manifested by a small-moderate association (range of .2–.4 approximately; Furr & Bacharach, 2013) with insight:

A. *Baseline alliance expectations*. Alliance expectations reflect the patient's general expectations regarding the relationship with the therapist and were found to predict a substantial part of the alliance to be formed (Barber et al., 2014). Higher insight, manifested by better understanding of interpersonal patterns, is expected to allow the patient to form and maintain more satisfying relationships, and enable flexibility in responsiveness to conflicts (Barber et al., 2013). Therefore, patients who have better recognition and higher understanding of interpersonal patterns are expected to have higher alliance expectations.

B. *Baseline interpersonal affiliation*. Interpersonal affiliation is characterized by a tendency toward friendly interactions, cooperation, and caring. Individuals with higher interpersonal affiliation are characterized by higher expectations from the relationship with the therapist (Dinger et al., 2013) and by lower levels of alexithymia, which refers to difficulties in psychically experiencing and verbalizing affects (Inslegers et al., 2012). Therefore, patients who have better recognition and higher understanding of interpersonal patterns are expected to have higher levels of affiliation (Gibbons & Crits-Christoph, 2017; Horowitz, et al., 2000).

C. *Baseline avoidant attachment*. According to the attachment theory, individuals with a higher level of avoidant attachment, are characterized by deactivation of the attachment system (Mikulincer, & Shaver, 2007) which aims to avoid the frustration and distress caused by the unavailability of attachment figures (Mikulincer et al., 2003). This is accomplished either by ignoring vulnerabilities or by avoiding distressing thoughts or memories, and therefore they tend to be less emotionally open to intimate interactions (Cassidy & Kobak, 1988; Mikulincer et al., 2003). In addition, individuals who are more avoidant tend to have lower levels of reflective function (Fonagy & Luyten, 2009) and higher levels of alexithymia (Simonsen et al., 2021). Therefore,

patients who have better recognition and higher understanding of interpersonal patterns are expected to be less attachment avoidant.

In regards to the discriminant validity, we examined the association between the SUIP-I and self-esteem. We based our hypothesis on the understanding that it is of high importance that discriminant validity is weaker than convergent validity (Hubley, 2014). Thus, we expected the correlation to be weak (in the range of approximately .0–.2).

D. *Baseline self-esteem*. Insight is expected to be weakly associated with the patient's self-esteem, as previous research has found a weak, nonsignificant relationship between insight and self-esteem (Connolly et al., 1999).

Method

Trial Design, Treatments, and Participants

A subset of 55 patients enrolled from the main trial phases and the pilot phase of a randomized controlled trial (RCT) received psychodynamic psychotherapy for depression (Zilcha-Mano et al., 2018). Individuals who met the inclusion criteria and did not meet the exclusion criteria were randomly assigned to one of two treatment conditions: "supportive" or "supportive–expressive" (for details, see the Supplemental Material). All participants provided written and oral informed consent and the procedures were approved by the internal review board of the institution. Demographic and clinical characteristics of the sample appear in Supplemental Table S1.

Scale Development

The SUIP-I is a clinician-administered interview which was developed by Gibbons, and Crits-Christoph (2017) and is based on the SUIP self-report (Connolly et al., 1999; Gibbons et al., 2009). In the present study, we focus on the development of a coding system for the SUIP-I, which assesses the patient's level of insight based on their responses during the interview. The process of developing the Likert scale included four steps: (1) The interviewers reviewed a set of 47 interviews conducted in the lab to grasp the full variability between patients. Since variability was inherently reduced due to symptom severity among the patients in the study, we examined both pre- and posttreatment interviews for step one. Each of the interviewers built the scales separately for each level. (2) We consulted with experts in the field regarding the face validity and the hierarchy of the scales. (3) The interviewers discussed and reviewed the resulting Likert-scales from the first and second steps in a weekly meeting and finalized them, while going over the interviews to grade them and confirm we had achieved a high level of standardization. (4) The developers of the tool (Gibbons & Crits-Christoph, 2017) reviewed the scales and provided feedback. This four-step process resulted in six Likert scales, with five levels for each. The full description of the SUIP-I coding system appears in Supplemental Table S2. As insight is viewed as a holistic, multidimensional concept, the total score was calculated as an average of all six levels across the five different stories, higher resulting scores indicating a higher level of insight. Accordingly, when assessing convergent and discriminant validity, the average scores were compared.

In the present study, the interviewers were graduate students, who received training and weekly supervision in the administration of the SUIP-I. Information regarding the training, supervision and ranking process appears in the Supplemental Material. SUIP-I interviews were face-to-face until the start of the pandemic (COVID-19), which resulted in 13 patients being interviewed remotely using secured software.

Measures for Testing Convergent and Discriminant Validity

Alliance expectations were assessed using the Expectations Working Alliance inventory–Short Form pretreatment (Barber, et al., 2014; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989). *Interpersonal affiliation* was assessed using the Inventory of Interpersonal Problems–Circumplex (IIP-C; Alden, et al., 1990; Horowitz, et al., 1988). *Attachment orientation* was assessed using the Experience in Close Relationships Scale (ECR; Brennan, et al., 1998). *Self-esteem* was assessed using Rosenberg's self-esteem scale (RSE; Rosenberg, 1965). Details of the measures and their reliability appear in the Supplemental Material.

Data Analysis

The reliability of the SUIP-I was assessed by internal consistency (Cronbach's α) and interrater reliability, ICC (1, 1); Shrout & Fleiss, 1979. The SUIP-I convergent validity was tested using Pearson correlations with the Expectations Working Alliance inventory–Short Form pretreatment, ECR-avoidance and IIP-affiliation. For discriminant validity, Pearson correlations with the RSE were used.

Results

Descriptive Data and Internal Consistency

Table 1 shows the mean, standard deviation, minimum, maximum, range, quartiles, skewness, kurtosis, and interrater reliability of the SUIP-I total score and for each of the six levels. The internal reliability of the SUIP-I was good (Cronbach's $\alpha = .81$, $N = 55$).

Convergent and Discriminant Validity

Regarding convergent validity, consistent with our hypothesis, the SUIP-I demonstrated a small significant positive association with alliance expectations (see Table 2), suggesting that these are two somewhat separate constructs. To a certain extent, patients with higher levels of insight into their interpersonal relationships also hold more positive expectations for their relationships with their therapists. Similarly, consistent with our hypothesis, the SUIP-I had a moderately significant positive association with the IIP-affiliation dimension, suggesting that individuals with higher levels of insight show a higher tendency toward friendly interaction with others. The magnitude of this correlation coefficient remained the same while controlling for the IIP-Dominance dimension ($r_{partial} = .31$, $p = .02$). Regarding avoidant attachment, consistent with our hypothesis, there was a negative, small significant association, suggesting that those with higher levels of insight also show lower levels of avoidance. The magnitude of this correlation coefficient remained the same while controlling for anxiety attachment ($r_{partial} = -.27$, $p = .04$). The discriminant validity of the SUIP-I was established by association with the patient's self-esteem (RSE). As expected, there was a weak and nonsignificant association, indicating that the SUIP-I measures a distinct construct.

Table 1
Descriptive Statistics and Interrater Reliability of the SUIP-I

SUIP-I by level	*M* (*SD*)	Min	Max	Range	Q1	Q2	Q3	ICC	Skewness *SE* = 0.32	Kurtosis *SE* = 0.63
Level 1	2.90 (0.66)	1.2	4	2.8	2.4	2.8	3.4	0.96	−0.23	−0.54
Level 2	1.95 (0.56)	0.4	3.8	3.4	1.6	2	2.4	0.91	0.14	1.65
Level 3	0.8 (0.68)	0	3.2	3.2	0.4	0.6	1.4	0.95	1.05	1.46
Level 4	1.11 (0.78)	0	3.2	3.2	0.4	0.8	1.8	0.92	0.58	−0.44
Level 5	0.71 (0.66)	0	3.8	3.8	0.2	0.6	0.8	0.93	2.14	7.89
Level 6	0.61 (0.69)	0	4	4	0	0.4	0.8	0.97	2.42	9.51
SUIP-I total	1.35 (0.47)	0.47	3.3	2.83	0.97	1.33	1.67	0.95	1.19	4.07

Note. $N = 55$. Interjudge reliability for this sample, calculated as one-way random effect (Shrout & Fleiss, 1979) based on 34.5% of the interviews ($N = 19$). ICC = intraclass correlation coefficient; SUIP-I = Self-Understanding of Interpersonal Patterns Scales–Interview; *SE* = standard error.

Sensitivity Analysis

Controlling the mode of delivery (in-person vs. remotely) as a binary variable, the findings and interrater reliability remain similar to those reported in the original analysis. In addition, findings remain similar to those reported in the original analysis after correcting the skewness using Log transformation. To test the theoretical assumption that the SUIP-I is hierarchically structured, a scalogram analysis was conducted which indicated that the SUIP-I in our sample does not support a hierarchical structure (see the Supplemental Material, for more details).

Discussion

The present study developed and initially validated a coding system for evaluating the insight level of a patient based on a clinical semistructured interview conducted with the patient, the SUIP-I (Gibbons & Crits-Christoph, 2017). The proposed comprehensive coding system extends its original coding system, which is binary in nature, to include a Likert scale for each of the six levels. The internal reliability of the SUIP-I coding system was good (Cronbach's $\alpha = .81$). Similarly, the interrater reliability of each of the six levels, as evaluated by the agreement between two independent coders, was in the excellent range (Portney & Watkins, 2009). The average level of insight in the sample prior to treatment was low among most individuals, and the coding system was able to capture the differences between patients. The SUIP-I showed support for convergent and discriminant validity. Consistent with our hypothesis, higher levels of insight were found to be associated with higher levels of alliance expectations and affiliation, and lower levels of avoidant attachment. In addition, insight was not meaningfully related to self-esteem (Connolly, et al., 1999).

Table 2
Pearson Correlations Between the SUIP-I and Measures to Determine Convergent and Discriminant Validity

			SUIP-I	
Measure	*M*	*SD*	*r*	*p*
EWAI	5.16	0.64	.29*	.034
IIP-affiliation	3.38	9.97	.30*	.027
ECR-avoidance	4.05	1.09	−.29*	.031
RSE	23.31	4.64	−.16	.232

Note. $N = 55$. EWAI = Expectations Working Alliance Inventory–Short Form pretreatment; IIP-affiliation = Inventory of Interpersonal Problems–Circumplex; Avoidance attachment = Experiences in Close Relationships scale; RSE = Rosenberg self-esteem scale; SUIP-I = Self-Understanding of Interpersonal Patterns Scales–Interview; ECR = Experience in Close Relationships.
* $p < .05$.

Advantages of the SUIP-I

There are many advantages of the SUIP-I that make it a promising measure in psychotherapy research and practice. The SUIP-I measures patients' level of insight directly by asking insight-related questions rather than indirectly based on information (e.g., therapy sessions) that was not designed to measure insight. These sources of information may add undesired variability in the obtained insight ratings. For example, a patient's insight coded based on therapy sessions can be influenced by the orientation and techniques the therapist uses, such that the patient's answer does not reflect their actual level of insight, but rather the patient's responses to the specific therapeutic technique used by the therapist. In addition, the SUIP-I interviewers are trained to evaluate the level of insight in a manner that is not affected by the patient's awareness and understanding of their own level of insight. For example, in the case of low insight, patients might not be aware of their maladaptive relationship patterns and unconscious conflicts, so that using a self-report measure might report higher levels of insight than they actually have (Jennissen et al., 2020).

Clinical Implications

The SUIP-I has a clinical utility, and the interview can be used at different time points for different purposes. At the beginning of treatment, information about the starting point of the patients' level of insight may serve as a guide for therapeutic work. For patients with higher levels of insight, this high level of insight may serve as a strength which the therapist can use as a base to facilitate an understanding of how to deal with the current crisis. In contrast, for patients with lower levels of insight, the focus of the therapy may be on raising insight. The comprehensive understanding that the SUIP-I provides about the six levels of insight can be used to plan therapeutic work on insight formation for specific patients, based on their specific map of milestones in each level. During treatment, the

SUIP-I can be used to evaluate the progress of gaining insight for treatment. At the end of treatment, it can be used to assess the extent to which the patient gained insight, whether the goals were achieved and how further change may be facilitated.

Limitations and Future Direction

Although the theoretical assumption is that the SUIP-I is hierarchically structured, a scalogram analysis that we have conducted indicates that the current data does not support such a structure. Such findings should be cautiously interpreted, given the small sample size, but if replicated in additional samples, the findings may suggest that different individuals follow different structures of insight. It may also be the case that there is a specific subpopulation, like the current sample, for whom insight does not follow a hierarchical structure and others for whom it does. Another aspect to take into consideration is that, although the SUIP-I was conceptualized consistently with the existing literature regarding the hierarchical structure of insight, it is possible that there is a more accurate depiction of insight that would manifest in a rearranged order of the levels of the SUIP-I, which future studies should investigate. For example, it may be possible that in order to be able to tie current interpersonal patterns to past experiences, one must first be able to detect one's role in contributing to the repetition of the pattern.

The present study has several limitations that should be addressed in future research. The first is the small sample size. Due to the small sample size, the a priori hypotheses were not α-corrected. Second, the study was part of a larger RCT that did not include some of the available alternative measures to assess insight. Thus, the examination of converging validity could not be exhaustive and a future study should test the validity of the SUIP-I against other tools available for measuring insight, such as the Self-Understanding of Interpersonal Patterns Scale (SUIP; Connolly et al., 1999) and the Achievement of Therapeutic Objectives Scale (McCullough, et al., 2003). Third, the findings are specific to the characteristics of patients with MDD, and their validity should be further explored with other clinical populations. Finally, although the SUIP-I was designed to be less prone to social desirability bias, future research using the SUIP-I should take this bias into account and further explore to what extent it overcomes this bias.

The present study proposed an initial validation of the comprehensive coding system of the SUIP-I. Future studies should explore the prognostic potential, as well as the ability to assess changes following a diversity of treatment types, both as a mechanism of change and as an outcome in itself. In addition, future studies can demonstrate the clinical utility of the SUIP-I scaling system in a case report.

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