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In mental health care, large differences in perspective between individuals with psychosis and professionals are an everyday reality. Such discrepancies become apparent in the substantial number of patients judged to lack illness insight. This Perspective argues that 'illness insight' typically refers to patient conformity to medical views rather than denoting true understanding into their condition. We outline limitations of the current conceptualization of illness insight ('clinical insight') and discuss an alternative, narrative understanding, drawing on literature from various academic disciplines. After addressing definitional ambiguities, etiological complexities and methodological inconsistencies inherent to the current understanding, this paper highlights several normative, cultural and ethical issues surrounding clinical insight. A narrative approach allows patients to find more meaningful explanations that resonate better with the complexity of their experiences and tackles other problems identified with clinical insight. We argue that narrative insight is inherently co-constructed, emphasizing the shared meaning-making process between individuals with psychosis and professionals.

In dealing with illness—whether that be treating it, coming to terms with its consequences or finding support from loved ones—it intuitively seems important that those involved share some common reality about the nature and significance of the disease. In the field of mental health, however, this often turns out not to be the case because of routinely occurring "dramatic discrepanc[ies] of perspective"[1]. Such differences in perspective are particularly frequently observed in care for people with psychotic disorders[2].

Psychosis, conceptualized as a condition in which one's reality testing is impaired owing to hallucinations, delusions and/or formal thought disorders (such as disorganized thinking), often substantially impacts daily functioning[3]. Consider the following scenario: when a person is diagnosed with schizophrenia and has psychosis, with its consequences permeating all domains of life, it is probable that this person will feel pressed by mental health professionals and family members to initiate treatment with antipsychotics. Professionals and family perceive medication as the logical course of action, given the severity of symptoms. The person, however, might deny any problems ('There is nothing wrong with me'), reject the diagnosis as an explanation ('I am not ill') or attribute the symptoms to some other origin ('I have just been very stressed recently') and as a result refuse to start taking medication. Mental health professionals and family members become increasingly disillusioned, which in turn worsens the situation of the person. Such noncompliance is substantial among those diagnosed with psychotic disorders, as evidenced by studies reporting that more than half of patients do not adhere to prescribed regimens[4]. The 'dramatic discrepancies', however, extend beyond disagreements about medication, with the reality of modern-day psychiatry described as one of large discordances between consumers of psychiatric services and their providers across various domains[5].

In clinical practice, these discrepancies are mostly examined by focusing on the person with psychosis, who is then typically characterized as having 'poor insight' into their illness[1]. As discrepancies of perspective are very commonplace in mental health care, assessing insight into one's illness is an integral part of routine mental status examination[6–8]. Research has repeatedly demonstrated that between

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Table 1 | Summary of the differences between clinical and narrative insight as discussed in this Perspective

Clinical insight (prevailing conceptualization)	Co-constructed narrative insight (proposed conceptualization)
Lack of insight understood as a deficit arising from disease	Insight understood as a narrative approach, a result of a process of deliberation
Methodological concerns (regarding its definition and operationalization) not aligning with clinical observations	Needs more methodological development, grounded in service users-concepts and experiences
Privileges the meaning of clinician (power imbalance/epistemic injustice), disregarding authorship over meaning	Brings perspectives of different stakeholders into dialogue and negotiation
Neglects normative and cultural dimension of illness explanations	Acknowledges both the explanations of clinician and patients and recognizes cultural embedding
Associated with enhanced stigma and hopelessness	Directed at fostering hopeful and emancipating explanations
Neglects the importance of personal meaning-making as part of the recovery process	Stimulates the meaning-making process, and integration of illness experiences into a self-story

50% and 80% of patients diagnosed with severe psychotic disorders do not believe they have the disorder and are thus labeled as lacking illness insight[9]. It is indeed claimed that lack of insight is the single most common feature of the acute-psychotic phase and it has been suggested that it should be considered a primary symptom of schizophrenia[10]. The high prevalence of 'lack of insight' at the very least urges the field to examine the following notion: why are so many people categorized as lacking insight and what does this reveal about its current understanding in mental health care?

In this Perspective we argue that in medical discourse the term 'insightfulness' is typically used to describe a very specific phenomenon—that is, the clinical observation that the patient conforms to certain preconceived ideas the mental health professional holds about them and their illness[11]. These ideas encompass convictions the patient should adhere to and behaviors they should exhibit (with regards to their disease), such as accepting the diagnosis and adhering to the proposed treatment. Building on previous research, we posit that illness insight as such (herein referred to as clinical insight) primarily represents a type of (diagnostic) conformity, more so than genuine insight into the predicaments of individuals. In routine clinical practice, when insight is assessed and discordance between patient and clinician is encountered, further exploration of this disagreement often fails to occur and the patient is qualified as having poor insight. That gives rise to and perpetuates fundamental differences in the way the illness is understood and experienced, potentially contributing to further disagreements in care.

Alternative academic conceptualizations of insight that do justice to emancipatory developments in the field of mental health care, such as narrative insight, have been proposed, but have not yet gained traction in clinical practice. Our objectives encompass (1) a comprehensive critique on the prevailing notion of clinical insight, (2) an examination of the current understanding of narrative insight and the observed delay in clinical adoption, and (3) an advocacy for an alternative, more co-constructed view of narrative insight. Thereby, we provide an exhaustive analysis on the topic, drawing on literature from different academic disciplines, which can serve as necessary groundwork for further (multidisciplinary) research in this domain.

Identifying problems with the employment of illness insight in clinical practice and research

In the following section, the clinical utility of the concept of illness insight in its current form will be questioned through the examination of several definitional and operational concerns. We will also highlight relevant research findings regarding the impact of illness insight on disease outcomes in (chronic) psychotic disorders and summarize some issues identified within this field of study.

Definitional and operational concerns

Since its conception the notion of illness insight has undergone significant evolution. Insight was initially defined as "a correct attitude to a morbid change in oneself" and was often regarded as a dichotomous construct, either present or absent[12]. However, over time it has matured into a more nuanced, multidimensional concept, acknowledging varying degrees of insight[13]. In a commonly referred-to definition, poor insight in psychosis broadly comprises the following (roughly overlapping) components: lack of awareness of (1) the deficits caused by the disorder, (2) its consequences (for instance, in social functioning), and (3) the need for treatment (for instance, with antipsychotic medication)[1]. Nonetheless, in scientific literature the notion continues to suffer from definitional unclarity, as no straightforward and unanimous criteria exist to describe and measure insightfulness[14,15]. Moreover, the understanding of illness insight seems to be heavily influenced by prevailing clinical paradigms, which can be exemplified by the shift in the 1990s from regarding insight as awareness of self or self-experience to emphasizing awareness of mental disorder, mirroring the increasing dominance of the biomedical model[16]. The widespread use of the term insight in psychiatric practice may indicate a comprehensive understanding of what human insight entails but this is in fact not the case[17]. Illness insight is commonly (implicitly) treated as a unitary and universal construct, but this is rather premature given these complexities[18].

Possibly reflecting this definitional unclarity, different etiological processes have been proposed to explain the lack of insight observed in people with psychosis. Elowe and Conus[15] discussed how, in scientific literature, these explanations range from lack of insight as being part of a psychological defense mechanisms to it being due to anosognosia (a cognitive inability to be aware of a disorder). In other elaborate work, Lysaker et al.[19] distinguished the following possible explanations: (1) anomalous experiences (that is, the incomprehensible nature of psychotic experiences), (2) abnormalities in brain structure and functionality, (3) deficits in neurocognition, (4) deficits in social cognition, (5) deficits in metacognition, and (6) social and political factors. These 'processes' are likely to interact in complex ways (for example, abnormalities in brain structure/functionality may result in deficits in neuro-, social and metacognition), suggesting the need for an integrative etiological model, which is not in place at present[19–21]. Furthermore, scholars have discussed whether lack of insight should be understood as a primary symptom (that is, an integral part of a developing psychosis) or a secondary phenomenon (arising as a consequence of the psychotic symptoms)[9], but it can be questioned how useful such a dichotomy is, in light of the probable multifactorial and complex nature of the concept.

Unsurprisingly, these definitional and etiological unclarities render methodological variability. Different instruments to measure insight are used, which in turn use different dimensionalities of insight[14,21,22]. Two commonly used clinician-rated instruments—the Scale of Unawareness of Mental Disorder (SUMD) and the Positive and Negative Syndrome Scale (PANSS)—highlight this variability starkly. Whereas the PANSS assesses insight globally through one single item ('lack of judgment and insight'), the SUMD scores multiple dimensions of insight across its 74 items (and is consequently rarely used in routine practice)[13,23,24]. This variability does not only exist between scales: a recent systematic review unveiled considerable heterogeneity in the use of the SUMD and the interpretation of its results[25]. Although research suggests that scales show medium-to-high intercorrelations, the multidimensional nature of insight seems to not be well-accounted for in the design of those measures[26]. The adoption of

these instruments is influenced by the narrowing of the definition of insight, but it has also contributed to this trend[16]. As the instruments are used with the assumption that people with psychosis use the same terminology as their clinicians, they often assess 'labels' and not a thorough understanding of the predicaments of patients in their own 'language'[27]. Patients who report changes in the way they are experiencing the world and themselves (for instance, 'I notice I am more paranoid at times, and it often does not make sense') and thus are showing—at the very least—some insight are at risk of being deemed 'uninsightful'. It is evident then that more precise multidimensional scales that also accommodate differences in vocabulary and attributions applicable in a clinical setting are needed as well as other, more descriptive, instruments that do justice to the nuances at play in the understanding of disease and self.

Importantly, these definitional and operational concerns are also observed outside the clinical arena. Gurbai et al.[28] investigated the occurrence of the notion of patient insight in legal proceedings by analyzing published judgments, particularly in cases in which the decision-making capacity of the patient was questioned. The researchers arrived at similar conclusions: (1) the concept of insight was never defined, (2) decisions never referred to a specific insight assessment test, and (3) no judgments referred to relevant research on interpreting insight. Such unclarities are of particular concern as lack of insight is often used as a justification for not discharging patients from psychiatric detention[29].

Clinical observations are found to not align with how insight has been defined and operationalized. For instance, in a study tracking changes in insight over 24 months among individuals with acute-phase psychosis treated with intramuscular preparations of antipsychotics, clinicians reported substantial improvements in their insight, contrasting with minimal changes in patient-reported illness insight or attribution[30]. This discrepancy suggests that clinicians may be assessing a construct that does not correspond with developments experienced by their patients. Contrary to the current conceptualization of insight, it has been observed that lack of insight does not necessarily translate into a refusal to undergo treatment with antipsychotic medication[13,31]. Accordingly, qualitative inquiry into user perspectives among individuals receiving long-acting antipsychotic injections demonstrated that some disagree with their diagnosis but acknowledge the necessity of antipsychotic treatment[32]. Conversely, some patients, driven by personal attributions or meanings attached to their experiences, acknowledge their symptoms but choose to refrain from taking medication[33]. These divergent responses underscore the complexity of individual self-representations, which often do not always align with the notions of professionals, yielding seemingly contradictory findings. In order to provide validity to clinical decision-making and ensure the generation of meaningful results from research, there is an urgency to define, understand and operationalize illness insight more accurately.

Research on the relationship between illness insight and disease outcomes

Considerable research effort has been dedicated to studying the relationship between illness insight (specifically, the lack thereof) and disease outcomes in chronic psychotic disorders. When examining this relationship through the lens of the current understanding of insight—that is, a clash between what mental health professionals believe is the most suitable diagnosis, its primary symptoms and the optimal treatment approach on the one hand and the patient's own beliefs and actions on the other—it is easily understood that lack of insight negatively affects clinical outcomes, as these are often also determined by clinicians. It has been demonstrated that poor insight is, among other factors, correlated with severity of psychopathology (in particular, symptoms such as hallucinations and delusional beliefs), treatment noncompliance and community functioning (as reviewed in refs. 19,34). However, higher or increasing scores on insight have also been associated, albeit a weak association, with adverse outcomes such as depressive symptoms (as reviewed in refs. 14,22). This phenomenon is described as the insight paradox: increased insight, generally considered beneficial, paradoxically leads to adverse outcomes[30]. Although the confrontation with the impairments usually associated with severe psychotic disorders undoubtedly explains this in part, it also seems to be moderated by factors such as stigma[35]. Some studies describe this correlation with insight as well for suicidality but the results are equivocal[19,26].

It is important to highlight that much of the research linking illness insight to disease outcomes is correlational[11]. It shows cross-sectional associations between insight and (for instance) clinical prognosis but does not establish that lack of insight determines the progression of illness. Some of the observed correlations, such as between insight and medication adherence, have faced criticism, as these 'correlated outcomes' are contained in the very definition of insight[21]. Moreover, relationships between psychopathology and insight are to be expected, as in severe illness patients will be strongly convinced of the validity of their psychotic experience and will oppose the viewpoints of the clinician[11]. Furthermore, the associations between insight and disease outcomes are typically weak, suggesting the involvement of other factors influencing that relationship[13,14]. To deepen our understanding of clinical insight and its role in psychotic disorders, there is a need for more studies investigating its evolution throughout the course of the disease and treatment[19].

Given the observed correlations with various (adverse) disease outcomes, improved insight has been considered a worthwhile target for therapeutic interventions. Nonetheless, relatively few studies have investigated insight as a primary treatment target of psychological and pharmaceutical interventions[18,26,36]. Pijnenborg et al.[18] state that clinicians might assume insight to be an artifact ('byproduct') of symptoms and anticipate its improvement when symptoms subside. Given the weak associations with symptomatology and disease outcomes, such assumptions are subject to debate. Alternatively, it might be that clinical insight has not progressed to become a tangible therapeutic target due to the described lack of definitional and methodological consensus.

The discussed concerns clearly underscore the fragility of the concept illness insight: if it is so difficult to conceptualize and operationalize, and few interventions are developed to target it, what then is the clinical utility of the concept in its current shape?

Normative, cultural and ethical concerns regarding the use of illness insight in psychiatric discourse

The above-mentioned methodological criticisms call attention to deeper concerns about the way mental health professionals and scholars typically understand illness insight, which we alluded to in the introduction of this Perspective. In this section, we will provide an overview of several fundamental concerns that tie into the complexity of the notion of insight into one's condition: inherent power imbalances and disregard of authorship over meaning, disregard of the cultural embedding and the complexity of illness explanations, the impact of stigma associated with psychotic illness and disregard of meaning-making as a (or part of a) recovery process.

Inherent power imbalances and disregard of authorship over meaning

We have already argued that the term insightful is used in cases when patients adhere to normative notions the mental health professional holds about them regarding (desirable) beliefs they should conform to and behaviors they should exhibit. As clinicians generally ascribe to the biomedical model (or, within the psychiatric context, the biopsychosocial model) to explain and deal with psychosis, their patients are also expected to agree with that model: they need to acknowledge certain

ideas regarding disease attributions and accept medical treatment[11,37,38]. It is inherent to this understanding of clinical insight that power over the meaning of illness lies exclusively with the professionals, creating a power imbalance that has long been contested by the psychiatric users/survivor movement[39,40].

Korsbek[41], integrating scientific literature on illness insight with her personal recovery experiences, highlights that substantial asymmetries in the clinician–patient relationship and in the understanding of disease create a clinical reality in which there exists 'very little room for the subjective viewpoint of people with lived experiences'. In philosophical literature this phenomenon has been termed epistemic injustice in which 'a hearer does not take the statements of a speaker as seriously as they deserve to be taken'[42]. Vulnerability to such injustice may be compounded by the conviction that people with mental disorders are susceptible to impairments of functions (generally deemed) necessary to engage in (medical) encounters as well as by other negative stereotypes pertaining to psychiatric illness[43]. Another factor contributing to this disparity is the entrenched perception of the medical professional as 'the dominant knower' that provides the framework through which claims are tested[44]. Mental health professionals, while assessing insight, take their reality as the 'gold standard', thereby implicitly disregarding the reality and experiences of their patients[20].

Disregard for the authorship of meaning need not to be overt and might also be the result of how clinical encounters are organized. Walsh[45] elucidates a subtler form of 'silencing' user perspectives in therapeutic contexts, where conflicting 'voices' emerge, such as the voice of the lived experience and the voice of therapy goals. Through analysis of conversations between people with schizophrenia and a speech and language therapist, it was found that the therapist sometimes manipulates talk that is not in line with treatment goals (such as delusional talk), potentially driven by 'agenda-driven' limitations, effectively silencing or 'hushing' lived experiences.

Although these instances of silencing underscore the need to critically examine power dynamics more broadly, the current notion of clinical insight, with its definition foregrounding the dominance of the biomedical model, specifically perpetuates these injustices and might as such perturb meaningful therapeutic interactions. Rather than as a primary symptom of psychosis, illness insight should be understood as a deeply norm-dependent notion, with beliefs rooted in the biomedical model. This is particularly concerning given the fact that the way psychotic disorders are classified remains contested[46].

Disregard of the cultural embedding and the complexity of illness explanations

A further fundamental problem with clinical insight is its disregard of the cultural embedding of psychotic experiences and the complexity of illness explanations. When illness insight is confined to diagnostic conformity, potentially valuable insights into the complexity of the 'lived psychotic experience' are lost.

Illness insight, as currently defined and operationalized, predominantly reflects Western, traditionally scientific, concepts of disease, thereby sidelining alternative explanations[6]. In reality the various ways in which people interpret and attribute the symptoms of their psychosis reflect their "sociocultural backgrounds, life experiences and other social determinants such as stigma"[15]. For instance, analyses of narratives from people in Canada with severe psychotic disorders reveal divergent explanations, with Canadian-born individuals often citing psychosocial factors or toxic agents, whereas immigrants tend to refer to spiritual factors or traumatic events[38]. Furthermore, a qualitative systematic review identifying six key themes related to spirituality that mattered in the lives of people with mental health difficulties highlighted that considerable gaps exist between the spiritual needs of patients and services provided by mental health professionals, ascribing these gaps to a (disproportionate) focus on the biopsychosocial model[47].

Unfortunately, most studies on insight fail to recognize the pivotal role of cultural factors in shaping the experiences of individuals and making sense of their predicaments[38,48]. Remarkably, a recent perspective article outlining future directions in our understanding of insight makes no mention of culture at all[46]. Moreover, even in studies that take a broader view of insight, very few acknowledge the fact that the opinions of professionals about insight are themselves "culturally and historically embedded"[16]. This prompts an exploration of how past interpretations of insight, shaped by cultural and historical contexts, might continue to inform and shape present-day research methodologies and conceptual frameworks. The same study states that considerations about the importance of culture tend to complement, rather than contradict, biomedical theories, raising questions about whether the impact of culture on an individual's interpretation of psychotic experiences is then truly acknowlegded by professionals.

Various qualitative studies offer invaluable insights into the diversity and complexity of illness explanations, which include but extend beyond mere cultural influences. Beliefs about the origins, nature and preferred treatment of psychosis are demonstrated to vary greatly between the two major stakeholders in the clinical encounter—the mental health professional and the patient. Oren and colleagues reviewed 42 studies that examined the beliefs regarding the origin of psychotic experiences in both individuals with psychosis and mental health professionals, and found that both groups hold views comprising 'complex causal models', integrating different types of causal belief[49]. It was found that mental health professionals (unsurprisingly) tended to endorse biogenetic beliefs, emphasizing influences such as heritability and the need for pharmacological treatment. By contrast, people with psychosis were more likely to endorse psychosocial and other nonbiogenetic beliefs, which emphasizes influences such as trauma and upbringing and the need for psychosocial interventions. In addition, people with acute psychosis were more likely to believe that their condition was "part of the human experience" rather than viewing it as a psychosis or mental disorder. Another intriguing discrepancy arises between professionals and loved ones: a study that investigated viewpoints of patients, their entourage (family members and close friends and family) and clinicians, revealed that the insight of the entourage members was significantly correlated with that of the patients[38]. In other words, entourage members, who do not have psychosis themselves, often exhibit a significant lack of insight, at least from the perspective of the professional. Research has increasingly demonstrated that individuals with psychosis understand and explain their condition in complex ways, subject to ongoing revision and integration of new perspectives. For instance, a meta-analysis, comprising 24 studies with 373 participants, using thematic synthesis provided rich insights into delusions, offering a model that explains how delusions emerge and are shaped by different factors rather than merely categorizing them as erroneous beliefs[50]. The result of such work is a 'thick description' of lived experiences that extends beyond clinical descriptions, which also demonstrates that investigating lived experiences is possible on large scale, adding to the robustness of their research findings.

As discussed earlier, individuals hold a melange of different, possibly contradictory, explanations to explain their psychotic experiences[6,51]. They tend to seek diverse forms of help, often both within traditional medical settings and through alternative circuits[52]. These findings offer a cue to change our understanding of clinical insight: what if we approach clinical insight as another example of such explanations? Some scholars have already explored this perspective: for instance, Jacob[11] puts forward that adhering to the collection of ideas that would mark one as having illness insight might just be one possible 'explanatory model' by itself. In the context of health care, explanatory models are "notions about an episode of sickness and its treatment which are employed by all those engaged in the clinical process"[53].

Naturally, such notions diverge, as understanding of disease emerges from "a complex mixture of cultural background and personal experiences, beliefs and expectations"[13]. Like other explanations, possessing clinical insight may then reflect attempts at coping with consequences of severe disease; in this case through believing that increasing difficulties with meeting life's demands might be ameliorated by medical assistance. Such an interpretation is fundamentally different from how insight is commonly understood in mental health practice and research as an 'independent psychopathological factor'[15]. Instead of viewing (lack of) insight as a deficit arising from disease (or staying intact despite it), insightfulness as such could be interpreted as a "culturally construed version of experience that [some] patients subscribe to, not simply because their cognitive machinery is intact, but by virtue of the way it fits with their social world"[54].

It is a very realistic scenario that convictions held by clinicians simply 'do not work' for their patients[20]. By contrast, when illness insight is understood as one possible explanatory model, lack of insight no longer refers to a 'feature' of the person with psychosis but instead describes a clash between the explanatory frameworks that the clinician and the patient adhere to. From a phenomenological standpoint, framing insight in terms of this clash seems more accurate, leaving room to explore and recognize the experienced reality of both stakeholders. Next, it becomes clear that the assumption that people hold solitary (and consistent) beliefs about their illness seems rather unrefined, representing a critical flaw in contemporary understanding.

The impact of stigma associated with psychotic illness

Another reason, whether consciously acknowledged or not, to forfeit a biomedical (biopsychosocial) perspective and seek alternative explanations to grasp psychotic experiences is the pervasive stigma associated with psychosis: schizophrenia is the most stigmatized classification category of severe psychotic disorders[55,56]. As previously discussed, individuals with severe psychosis with heightened (self-)stigma are more prone to depression and potentially face an increased risk of suicide[14,19,22,26]. In a health-valuing culture, people are aware to what extent they adopt health practices and assess other people accordingly[57]. Health-promoting behaviors and 'being healthy' become features of identity. Self-stigmatization occurs when individuals internalize these beliefs, possibly leading to diminished self-esteem and self-efficacy[58]. It causes barriers to pursue life goals, contributing to feelings of despair and hopelessness. Research suggests that the interplay between insight and stigma has a crucial role in determining the level of hope experienced by an individual and by extension other factors that determine their quality of life[35]. Patients with high levels of insight and high internalized stigma tend to have the lowest levels of hope and vice versa. In addition, stigma influences how patients tend to appraise their psychotic experiences and deal with them during recovery: some tend to 'seal over' such experiences, whereas others integrate them in their lives[59]. The sealing over group generally considers their psychosis as separate from the rest of their life, using this strategy to maintain mental integrity and protect themselves from stigma (that is, they could be considered insightless). The integration group, in contrast, discusses their symptoms more openly and comply with treatment.

Stigma might thus foster feelings of hopelessness and can prompt patients to search for different interpretations. This phenomenon was highlighted in a qualitative study on the meaning-making of trauma in psychosis[60]. Participants cited stigmatizing beliefs in mental health care (for example, 'not able to develop self-insight or coping') hindering their ability to connect psychosis with their traumatic life experiences. They often found support in creating helpful and empowering meaning outside mainstream psychiatric services. Such findings underscore that instances in which patients disagree with mental health professionals are not always incomprehensible and surely not invariably pathological.

Disregard of meaning-making of illness as a (or part of a) recovery process

Last, we argue that the notion of clinical insight is at odds with the transition towards person-centered, recovery-oriented care[61]. The recovery paradigm used in mental health care includes the aim that individuals with severe psychiatric illnesses can "reclaim life" or "create a newly meaningful one"[62] even if mental illness persists[63]. It emphasizes person-centered care, increased self-determination and a shift from symptom reduction to restoration of function[64]. This contrasts with the more traditional cure-oriented concept of clinical recovery, which focuses on symptom remission[65]. Instead of rapid stabilization and symptom relief, the recovery model seeks approaches to assist the individual to (re)gain a meaningful identity and satisfactory life by "promoting hope, attainment of personal goals, social inclusion, and supportive relationships"[66]. Importantly, it has been shown repeatedly that clinical improvements do not always align with personal recovery, which suggests that conventional treatments might fall short in promoting overall recovery[37,67,68].

The emergence of the recovery-oriented ideology has prompted investigations into how illness insight influences subjective aspects of recovery. Recent research indicates that the level of clinical insight is not a significant factor in predicting subjective recovery[37]. By contrast, it has been suggested that higher levels of clinical insight hinder such recovery through mediation of increased negative emotions such as anxiety and low self-esteem[69]. The act of labeling psychotic symptoms as such could exacerbate distress and convey messages of hopelessness and lack of agency. A cluster analysis of individuals diagnosed with schizophrenia identified distinct subgroups in which various self-reported personal recovery and clinical outcome measures (such as symptom reduction) were compared[70]. Outcomes were equivocal for two clusters: the first displayed positive features of recovery (both self-reported and clinical) and the third showed negative features. However, in the second cluster, which had the highest insight scores, a more complex pattern was observed, with conflicting positive and negative self-reported and clinical features. Rossi and colleagues conclude that illness insight "may complicate the relationship between self-reported personal and clinical elements of recovery"[70].

Conversely, empirical studies have demonstrated that idiosyncratic meaning-making processes are crucial for personal recovery. Qualitative studies into service users' perspective on recovery identified meaning-making of mental distress as an (initial) task of personal recovery[71–76]. Quantitative studies provide statistical support for the association between adaptive meaning-making and psychological well-being and growth[77–81]. In the recovery movement, forming one's own story is seen as a deeply emancipating process that helps individuals to disentangle from a passive patient identity and reclaim authorship over their own life[40]. Making and sharing one's story is therefore a key instrument of peer support applied in recovery colleges[82]. In mental health care, meaning-making of illness as part of the recovery process is disregarded or replaced when people are offered ready-made medical explanations for their conditions (for instance, in the form of psychoeducation on schizophrenia)[72].

Based on these findings, we propose that persisting with terminology regarding clinical insight, as well as the pursuit of achieving such insight within patients, could impede or even obstruct further realization of the goals of recovery-based psychiatry. A reductionist understanding of insight can damage the therapeutic alliance, as it dissuades a modus operandi of exploring differences and finding consensus. Developing insight then "does not assist the patient in his endeavor for self-knowledge but rather leads him to accept the presence of a disorder and its potentially poor prognosis"[15]. The notion of illness insight should therefore be revisited and embedded within the recovery model to facilitate such endeavors for self-knowledge.

Towards co-constructed narrative self-insight

Having scrutinized the concept of clinical insight, we will now discuss an alternative conceptualization of insight that addresses the limitations

associated with clinical insight. In addition, we will briefly explore its adoption into clinical practice and propose avenues for future research.

Narrative insight

Prompted by the ongoing debate regarding the limitations of clinical insight, scholars have developed an alternative framework for comprehending the insight of individuals into their condition, known as narrative insight[20,51]. The concept of narrative insight can be situated within the broader academic discourse on 'narrative identity'—a theoretical and empirical perspective asserting that individuals function as autobiographical authors that construct their own life stories based on personally significant experiences[83]. Research suggests that people with psychotic disorders experience a profound loss of self and a diminished capacity to forge meaningful narratives about themselves[72]. As previously noted, however, developments in self-understanding are pivotal in progressing towards health and well-being[84]. Expanding on these findings, various authors—notably Roe et al.[85] and Tranulis et al.[86]—have postulated that a meaningful assessment of insight involves examining the extent to which individuals have been able to make sense of their predicaments, rather than solely evaluating their adherence to biomedical explanations.

Insightfulness as a narrative would thus entail construing a personal narrative, where one draws from a "culturally informed repertoire of possible explanations, which may or may not include the notion of illness"[20]. Developing insight as such is a 'narrative act', which enables (and incentivizes) patients to find a meaningful and useful explanation that fits them and resonates with their experiences[87]. This adaptive, narrative approach stands in stark contrast with the static definition of clinical insight. Importantly, it still necessitates a certain level of insight on the part of the patient involving the recognition of "some kind of nonvisible change in his or her body or mind that affects the ability to function socially, and if he or she feels the need for restitution"[52]. The reconceptualization of insight as a narrative does justice to various complex facets of insight: for instance, it allows for the acknowledgment that one's mental dysregulation and the 'disease label' (that is, the strictly medical understanding, interpretation and explanation) often do not correspond[51]. In addition, embracing insight as a narrative aligns with the conversational nature of the clinical encounter—conveying insight then not only represents what one believes but also acknowledges the importance of the 'audience' that receives or assesses the message[86].

Various studies have expanded on the notion of narrative insight, seeking to validate its theoretical aspects in the real-life meaning-making process of individuals with psychosis. For instance, researchers investigated (through inductive analysis of personal accounts) how participants utilized spiritual and religious explanatory frameworks to interpret their psychotic experiences[88]. Participants were shown to critically evaluate their preference for such explanations, often subjecting these to testing (rather than taking them for granted); some also acknowledged the validity of biological explanations alongside alternative interpretations. In the subsequent sections, we will provide further examples of how scholars are substantiating the notion of narrative insight and associated concepts with empirical evidence. Table 1 summarizes the differences between clinical and narrative insight as discussed in this work.

Stimulating patients in their quest for personal meaning

In the 'Disregard of meaning-making of illness as a (or part of a) recovery process' section we underscored the importance of meaning-making in personal recovery and the limitations of clinical insight in acknowledging this process. It has been demonstrated that individuals who report (personal) recovery are more likely to have developed a meaningful interpretation of their psychosis[89]. Similarly, recent experimental research asserts the importance of meaning-making in determining the distress associated with psychotic experiences and the trajectory of illness: when individuals with persistent psychotic experiences but who did not require care (nonclinical group) were compared with patients diagnosed with psychotic disorders (clinical group), the clinical group was found to exhibit more paranoid and personalizing appraisals of their psychotic experiences (and less normalizing and supernatural explanations)[90]. When both groups were exposed to experimentally induced anomalous experiences, the clinical group demonstrated more threatening explanations, highlighting the importance of interpretation for clinical status (that is, severity of symptoms and need for treatment). Notably, there are overlapping concepts such as 'appraisals', 'illness/causal beliefs' and 'explanatory frameworks' that are used interchangeably in the field.

Recognizing the importance of meaning-making, a transformation of the role of patients in their own recovery becomes imperative. Approaches to stimulate 'self-management' should be implemented, in which people are expected to make sense of their own predicaments and are more actively engaged in their personal recovery[91]. However, this might pose a challenge for people with psychotic disorders, as they struggle with metacognition—the ability to integrate information into coherent representations, which is necessary to form complex ideas about themselves and their surroundings[92]. This capacity is deemed indispensable for the attainment of narrative insight, thus underscoring the need for interventions targeting the enhancement of metacognitive abilities[19,93]. Such interventions are focused on mitigating the fragmentation of self, facilitating increased meaning-making by promoting construction of coherent narratives and improving agency[83]. Importantly, for deciding what interventions are suitable to equip patients with these skills, more research on appraisals of psychotic experiences—for instance, into the mechanisms underlying the formation of such appraisals—is needed[94].

When interviews with individuals experiencing early psychosis were analyzed (through a grounded theory approach), it was found that whether an individual arrives at clinical insight depends on an active process of deliberation in which 'finding a fit' with an explanatory framework was especially of importance[20]. Encouragingly, the authors posit that during this early phase of illness individuals exhibit the capacity to adapt their narratives: when these individuals sought (or accepted) medical assistance, they were observed to incorporate their earlier narratives into new ones. It suggests that individuals can attain meaningful and workable understandings of their predicaments with or without agreeing to medical discourse. Although the findings supporting this are at present limited and capture a subset of individuals with psychosis, it warrants further exploration. They point out that in examining insight, the cohesiveness of the explanatory framework of the individual, rather than the specific content, emerges as particularly relevant[20,88].

Co-constructed nature of illness insight

Conceptualizing illness insight along narrative lines offers the opportunity to foreground the inherently dialogical nature of insight into the (ill) self. It has been demonstrated that narratives of the self are not individual isolated constructions but take shape in a process of co-construction between individuals and those in their lived context[95], which encompasses not only family members and friends but health professionals as well. Although professionals can limit and stifle the process of co-construction[45], they can also stimulate it[96], thus fostering a co-constructed narrative insight. The overarching objective is to cultivate a 'shared narrative' that promotes recovery, rather than exacerbating distress and dysfunction[20].

Recent qualitative work provided a tangible example of this in the context of psychosis services by highlighting the co-constructed nature of hope in the narratives of the participant[97]. Through in-depth semi-structured interviews with stakeholders (that is, service users and providers), the authors assert that hope is, often implicitly, "co-constructed and managed within professional-user relationships".

Professionals have limited control over how their communication is interpreted and thus "need to become more alert to the way they knowingly or unwittingly manage the hopes of service users in their care". An earlier cited study also demonstrated how professionals at times influence the encounter by 'manipulating' talk not in line with treatment goals, which can frustrate this process of co-construction[45]. In the best scenario, interactive encounters should be geared towards arriving at normalizing explanations, reducing internalized stigma and improving self-esteem[69]. It is important to recognize that this is not an easy task, as the process will by definition be different for each individual.

We argue that true narrative insight is inherently co-constructed, emphasizing the shared meaning-making process between individuals with psychosis and professionals. Such a co-constructed approach tackles other identified problems with clinical insight, for instance, by addressing the power imbalance regarding the authorship of meaning and recognizing the complexity of illness explanations. This notion of a narratively co-constructed illness insight holds out the prospect of fundamentally recalibrating the clinical encounter and the role of clinical insights in this encounter. It accentuates the importance of what is said, the way this is delivered and the reciprocity of the encounter, akin to an intricate dialogical 'deal-making process': "If we see the process of diagnosis as a type of negotiation or trade, then making a deal will depend on what exactly is being offered, with what benefits, and at what price"[98].

Advancing narrative insight: bridging theory and practice through research

Critiques of clinical insight are not novel, as the review from 1992 by Markova and Berrios[99] attests to. Nonetheless, the integration of the concept of narrative insight into clinical practice remains notably absent, despite substantial 'groundwork'. In addition, many studies investigating aspects of insight in psychosis care continue to be framed within the paradigm of clinical insight. It seems that despite decades of theory development concerning narratives in psychosis (and, by extension, narrative insight), clinical, educational and institutional reality have yet to pivot away from the dominance of clinical insight.

Although it goes beyond the scope of this paper to thoroughly analyse the reasons for limited adoption of narrative insight, we hypothesize that hermeneutical injustice prevalent in psychiatric practice may contribute to this phenomenon. Hermeneutical injustice refers to the notion that 'a collective gap in hermeneutical resources' (that is, tools to understand, articulate and interpret experiences) makes that people are rendered unable to understand and their experiences are not further explored[43]. This may stem from limited participation in developing shared meaning resources—for instance, because of not being involved in shaping research agendas[44]. Addressing such injustices necessitates an "alertness or sensitivity to the possibility that the difficulty one's interlocutor is having as she tries to render something communicatively intelligible is due not to its being nonsensical or her being a fool but rather to some sort of gap in the collective hermeneutical resources"[100].

Personal accounts of individuals with psychosis have had, and continue to have, an important role in counterbalancing hermeneutic injustice, by making it possible to ground concepts such as recovery and insight in lived experience. As elucidated, the body of predominantly quantitative research may lack the contextual depth needed to grasp personal meaning-making and recovery experiences[32,101]. Although theoretical and philosophical contributions offer valuable perspectives, they lack grounding in clinical practice. By contrast, the qualitative studies captured in this Perspective have demonstrated that their methodological approaches can be used to deepen our understanding of (illness) insight in the context of psychosis. However, the existing body of qualitative research remains relatively limited: a meta-analysis of inductive qualitative research examining first-hand accounts comprised of a modest 98 studies conducted between 2000 and 2010 with a total of 1,945 participants[99]. Studies investigating psychosis care from the perspective of service users can elucidate crucial factors for improving and tailoring interventions[102] while also highlighting the ongoing challenges individuals face in exploring the meaning of their psychosis, even during periods of remission[103]. This research tradition thus needs expansion. A recent meta-ethnography of 17 studies with 609 participants in which the development of complaints in first episode psychosis were examined, revealing facilitators and barriers to help-seeking, provides an example[104].

Furthermore, we suggest that to advance our understanding of the development of narrative insight, it is necessary to gain deeper insight into the role of mental health professionals in the co-construction of narrative insight. Potential avenues include exploration of the barriers perceived by these professionals to cultivate such insight and investigation of how the process of co-construction of narrative insight unfolds and may be impeded (through direct observation of the 'lived experience' of clinical encounters). The advantage of focusing on insight within a broader discourse to address hermeneutical issues in mental health care lies in the fact that it can be studied within a framework already broadly adopted in psychiatric services (that is, the assessment of insight). Importantly, this will require mental health professionals to embrace doubt and undoubtedly gives rise to new questions—for instance, what should prevail: the therapeutic alliance or the treatment with antipsychotics? There is evidence for both approaches in medical literature but little guidance on how clinicians should consequently arrive at a decision[61]. Naturally, this poses difficult, but exciting, questions about how we envision the future of psychiatric care. For instance, how should our language change to align with this new understanding of illness insight? What resources and methodologies are available to increase our understanding of lived experiences? How can we reorganize the clinical encounter such that the co-construction of narratives occurs more organically? How do we equip (aspiring) mental health professions with the necessary skills to engage in this process? Central to this is an emphasis on cultivating health literacy that goes beyond medical concepts, making it imperative that professionals receive guidance in navigating these issues[105].

In summary, the concept of clinical insight suffers from several methodological as well as deeper normative, cultural and ethical concerns. Although critiques of clinical insight are not novel, its use in clinical practice remains ubiquitous. To ameliorate these concerns, which extend beyond the confines of clinical insight, further investigation into the utility of narrative insight is warranted. This necessitates research to substantiate the notion that patients with psychosis can construct adaptive narratives, explore potential interventions to enhance this capacity, identify how systemic barriers such as hermeneutical injustice are impeding implementation in clinical practice and develop strategies that mental health professionals can use to navigate these challenges. Such endeavors inherently demand a multidisciplinary approach, as underscored by the diverse array of disciplines included in this Perspective. It is imperative that mental health professionals become more aware of the importance of meaning-making in psychosis, delve deeper into the capacity of individuals with psychosis to engage in this meaning-making process and recognize the important role professionals themselves have in narrative co-construction. In doing so, mental health professionals will become involved in a more symmetrical process that fosters personal recovery, which might help bridge discordances in contemporary psychiatric reality.

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Author contributions

N.J.E. led the initial conceptualization and drafted the original manuscript. G.E.H.I.F., F.S., N.V.S. and S.M.V.G. contributed to this conceptualization; revised, reviewed and edited subsequent drafts of the paper, and read and agreed to the final version.

Competing interests

The authors declare no competing interests.

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