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Measuring Insight: A Comprehensive Look at Its Core Elements

İçgörünün Ölçülmesi: Temel Unsurlarına Kapsamlı Bir Bakış

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ABSTRACT

The present article discusses the concept of insight in terms of the scales in the literature that measure or assess insight. A search of Google Scholar and PubMed using the terms 'insight scale', 'insight questionnaire', 'insight survey', 'insight checklist', 'insight inventory' and 'insight + major psychiatric diagnostic categories' identified 44 scales that assess 6 different insight themes: 1) psychological insight, 2) cognitive insight, 3) clinical insight, 4) therapeutic insight 5) social insight, 6) Buddhist insight. Psychological insight is the state of awareness and understanding of one's own feelings, thoughts, beliefs, behaviours, personality, traits and whatever belongs to the self and the self's relationship with the environment. Cognitive insight assesses how inclined and intentional the person is to reflect on the cognitions he/she holds and at the same time how firmly he/she holds to his/her beliefs and cognitions and how much he/she believes in their accuracy. Clinical insight assesses awareness of the illness, importance of the symptoms and awareness of the cost of the illness. Psychotherapeutic insight is a type of insight that can be related to the patient's therapeutic rapport, in which the patient's awareness of himself or herself and the relationship he or she establishes with his or her environment during the sessions. While social insight brings the construct of insight a social context, Buddhist insight is an introspection or insight which is the aim of Buddhist or mindfulness practice. In conclusion, insight has a complex and unique construct which causes confusion while identify it comprehensively. Although there is an abundance of work on insight in the literature, there is still some way to go to elucidate this concept.
Keywords: Psychological insight, cognitive insight, clinical insight, psychotherapeutic insight

ÖZ

Bu makale, içgörü kavramını literatürde içgörüyü ölçen veya değerlendiren ölçekler üzerinden tartışmaktadır. Google Scholar ve PubMed'de 'içgörü ölçeği', 'içgörü anketi', 'içgörü testi', 'içgörü kontrol listesi', 'içgörü envanteri' ve 'içgörü + başlıca psikiyatrik tanı kategorileri' terimleri kullanılarak yapılan aramada 6 farklı içgörü temasını değerlendiren 44 ölçek tespit edilmiştir: 1) psikolojik içgörü, 2) bilişsel içgörü, 3) klinik içgörü, 4) psikoterapötik içgörü, 5) sosyal içgörü, 6) Budist içgörü. Psikolojik içgörü, kişinin kendi duygularının, düşüncelerinin, inançlarının, davranışlarının, kişiliğinin, örüntülerinin ve benliğine ait her şeyin ve benliğinin çevreyle olan ilişkisinin farkında olma ve anlama durumudur. Bilişsel içgörü, kişinin sahip olduğu bilişler üzerinde düşünmeye ne kadar eğilimli ve niyetli olduğunu ve aynı zamanda inançlarına ve bilişlerine ne kadar sıkı sıkıya bağlı olduğunu ve bunların doğruluğuna ne kadar inandığını değerlendirir. Klinik içgörü, hastalığın farkındalığını, semptomların önemini ve hastalığın yüküne dair farkındalığını değerlendirir. Psikoterapötik içgörü, hastanın terapötik uyumuyla ilişkilendirilebilecek, seanslar sırasında hastanın kendisi hakkındaki farkındalığının ve çevresiyle kurduğu ilişkinin değerlendirildiği bir içgörü türüdür. Sosyal içgörü, içgörü yapısına sosyal bir bağlam kazandırırken, Budist içgörü Budist veya zihinsellik pratiğinin amacı olan bir iç gözlem veya içgörüdür. Sonuç olarak, içgörü karmaşık ve benzersiz bir yapıya sahiptir ve bu da onu kapsamlı bir şekilde tanımlarken kafa karışıklığına neden olmaktadır. Literatürde içgörü üzerine çok sayıda çalışma olmasına rağmen, bu kavramın aydınlatılması için hala alınması gereken uzun bir yol bulunmaktadır.
Anahtar sözcükler: Psikolojik içgörü, bilişsel içgörü, klinik içgörü, psikoterapötik içgörü

Introduction

Gnothi Seauton (Greek), or 'Know thyself'. These words are inscribed on the door of the temple at Delphi. Although this saying has been attributed to a number of Greek sages, today it is most often identified with the Greek philosopher Socrates. Socrates argued that people should know themselves. In this case, self-awareness and self-knowledge were already a subject of thought in the 400s BC. Throughout the years, periods and ages, philosophy, psychology, religious studies, in other words, any field that deals with human beings under different names, has been concerned with the relationship between human beings and themselves, based on awareness, knowledge and recognition. Today, psychiatry and psychology use terms to describe people's perceptions,

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thoughts and feelings about themselves and their experiences, such as self-consciousness, self-awareness, insight, self-reflection and introspection.

Historically, the concept of insight in psychiatry emerged around the middle of the nineteenth century. Before that time, insight into mental illness was the answer to the question: Is the patient aware of his illness? In the middle of the nineteenth century, especially in France, there were debates about insight and attempts to conceptualise insight. Clinical insight was one of the most prominent concepts as a criterion for distinguishing between clinical disorders, as a prognostic variable. The concept was used to distinguish severe mental disorders, namely psychotic disorders, from milder forms of mental disorders, namely neurotic disorders. At that time, if a patient had good judgement, was able to be aware of his feelings and thoughts, could explain his behaviour, and finally was aware of his mental illness, it meant that he had good insight (Marková 2005).

Three important difficulties arise in the pursuit of what insight is. The first of these challenges relates to scope. While some define insight as awareness of only one condition or disease, others define it more broadly. For example, when we talk about impaired insight in patients with schizophrenia, we mean impairment of the awareness that the person has a mental illness, and that this mental illness needs treatment (Amador and David 1999). Others define insight in a broader context, making it more inclusive than focusing on a condition or disease (Grant ve al. 2002, Beck et al. 2004). The second major difficulty is that the concept that one school describes as insight is defined by another school by a different name, or there are differences in the content of the concepts that the schools call insight. The third is the state of nested conceptualisation. It is not possible to completely separate the concept of insight from self-awareness or self-consciousness (Fenigstein et al. 1975, Fenigstein 1984). In other words, in the definitions of the concepts called self-awareness or self-consciousness, there are expressions that overlap with the definition of insight. For example, being aware of oneself is also an aspect of insight. These difficulties prevent us from providing a comprehensive description of insight. At the same time, since studies are conducted by addressing only certain dimensions of insight, which have a complex and heterogeneous structure, it may be challenging to determine how a person's insight is. However, this situation is not the fault of those conducting the studies. It is caused by the lack of a common conceptual framework for insight. The lack of a common conceptual framework could be due to changes in the way philosophy, psychology and religious studies position human beings in the world and describe the relationship between human beings and the world. For example, in philosophy, human beings can be considered as beings who can think about themselves, whereas in empirical psychology they are rather considered as strings of emotions, thoughts and behaviour. Therefore, these different approaches may have influenced the way insight is handled.

The assessment of insight is essential in the diagnosis and treatment of psychiatric disorders. It is a powerful variable in the course of the illness, its progression, whether or not it becomes chronic, treatment resistance and compliance. Today insight is no longer considered as dichotomous, i.e. present or absent, but as a spectrum, and scales are invaluable in objectively assessing where individuals fall on the spectrum. At the same time, insight is not a one-dimensional concept. Different researchers have described different dimensions of insight and developed scales based on these descriptions.

In psychology and psychiatry, scales are developed to assess a concept. Scales are used to provide information about a patient's mental state in addition to clinical interviews. While it is important to develop scales, it is also important to know 'what' they measure. Given that insight has different dimensions, clinicians need to know 'what' is measured by insight scales that they can use both in the diagnostic process of patients, in their follow-up of patients and in their studies. Therefore, the aim of this article is twofold. First, to describe and conceptualise insight in the reverse order; of which dimension(s) of insight the scales measure, and second, to provide clinicians with a comprehensive guide to insight scales.

Scales Measuring or Evaluating Insight

A search of Google Scholar and PubMed using the terms 'insight scale', 'insight questionnaire', 'insight survey', 'insight checklist' and 'insight inventory' identified 35 scales. Three of these scales (the Diabetes Awareness and Insight Scale, the Obesity Awareness and Insight Scale and the Blood Pressure Awareness and Insight Scale) were excluded because they were scales that made assessments outside the field of psychiatry and psychology. The Insight Inventory scale relates to visual, visual-perceptual and visual-motor difficulties in children and was therefore excluded. The Sustainability Insight Scale is a scale related to human relationships and decision-making processes related to travel and was excluded because it assesses insights gained during travel.

Table 1. Brief presentation of scales	
Insight Theme and Definition	**Scales**
Psychological Insight	
Psychological insight is the state of awareness and understanding of one's own feelings, thoughts, beliefs, behaviours, personality, traits and whatever belongs to the self and the self's relationship with the environment.	Self-Reflection and Insight Scale
	Insight Scale for Nonclinical University Students
	Psychological Insight Questionnaire
	Psychological Insight Scale
	Coping Self-Insight Scale
Cognitive Insight	
Cognitive insight assesses how inclined and intentional the person is to reflect on the cognitions he/she holds and at the same time how firmly he/she holds to his/her beliefs and cognitions and how much he/she believes in their accuracy.	Yale-Brown Obsessive-Compulsive Scale
	Fixity of Beliefs Scale
	Body Dysmorphic Disorder Examination
	Yale-Brown Obsessive-Compulsive Scale Modified for Body Dysmorphic Disorder
	Brown Assessment of Beliefs Scale
	Overvalued Ideas Scale
	Beck Cognitive Insight Scale
	Insight Orientation Scale
	Nepean Belief Scale
Clinical Insight	
Clinical insight assesses awareness of the illness, importance of the symptoms and awareness of the cost of the illness.	Hamilton Depression Rating Scale
	Positive and Negative Syndrome Scale Insight and Judgement items
	Insight and Treatment Attitude Questionnaire
	Markova's Insight Scale
	Schedule for Assessment of Insight/Expanded
	Scale to Unawareness of Mental Disorder
	Birchwood Insight Scale
	Hanil Alcohol Insight Scale
	11-Item Insight Scale
	Self-Appraisal of Illness Questionnaire
	Psychosis Evaluation Tool for Common Use by Caregivers
	Mood Disorders Insight Scale
	Measure of Insight into Cognition
	Insight Scale for Affective Disorders
	VAGUS Insight into Psychosis Scale
	Signs and Symptoms of Psychotic Illness
	Q8 Questionnaire
	Schedule for the Assessment of Insight in Eating Disorder
	Alcohol Use Awareness and Insight Scale
	Substance Use Awareness and Insight Scale
	Nicotine Use Awareness and Insight Scale
	Gambling Awareness and Insight Scale
	Risk Insight Scale
Psychotherapeutic Insight	
Psychotherapeutic insight is a type of insight that can be related to the patient's therapeutic rapport, in which the patient's awareness of himself or herself and the relationship he or she establishes with his or her environment during the sessions.	Session Impact Scale
	Capacity for Dynamic Process Scale
	Shedler-Westen Assessment Procedure (SWAP) Insight Scale
Social Insight	
Social insight brings the construct of insight a social context.	Social Insight Scale
Buddhist Insight	
Buddhist insight is an introspection or insight which is the aim of Buddhist or mindfulness practice.	Ireland's Insight Scale
	Mindfulness Insight Scale

The search strategy was extended to include the terms 'insight + major psychiatric diagnostic categories. The major psychiatric categories were identified according to the DSM-V-TR: neurodevelopmental disorders, schizophrenia spectrum disorders and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, sleep-wake

disorders, substance-related and addictive disorders, personality disorders, paraphilic disorders. In addition, 14 scales were identified.

Articles published between 1960 and 2024 were scanned and only articles written in English were included in the study. Poster presentations, letters to the editor and short papers were not included in the study. Exceptionally, the native language of the Q8 questionnaire was French, and both the original article and the article in which the English adaptation was made were cited.

In line with the analyses of what the scales of the remaining 43 scales assess, 6 different insight themes were proposed: 1) psychological insight, 2) cognitive insight, 3) clinical insight, 4) therapeutic insight 5) social insight, 6) Buddhist insight. While a brief presentation of scales is exhibited in Table 1, a more detailed list of the scales evaluated is given in Table 2.

Table 2. List of the scales

	Author(s) and Publication Year	**Item Counts**	**Type**	**Psychometric Properties***	**Target**	**Subscales/ Subdimensions**	**Additional information**
Psychological Insight							
Self-Reflection and Insight Scale	(Grant et al. 2002) Turkish version: (Duysal and Çetin 2017)	20	Self-report	2 factors Cα = .91 (Self-reflection); .87 (insight) TRR= .77 (Self-reflection); .78 (insight)	Both general population and different clinical population	Self-reflection Insight	The scale assesses insight and self-reflection as part of self-consciousness.
Insight Scale for Nonclinical University Students	(Akdoğan and Türküm 2018)	20	Self-report	3 factors Cα= .84 (Total); .80 (Holistic view); .69 (Self-Acceptance); .78 (Self-Understanding TRR=.84 (Total)	General population	Holistic view Self-Acceptance Self-Understanding	The scale assesses psychological insight in non-clinical university students.
Psychological Insight Questionnaire	(Davis et al. 2021)	23	Self-report	2 factors Cα= .93 (AMP); .85 (GAP) TRR= N/A	Not defined	Avoidance and maladaptive patterns insight (AMP) Goal and adaptive patterns insight (GAP)	The scale assesses acute psychological insight following psychodelic use.
Psychological Insight Scale	(Peill et al. 2022)	6	Self-report	1 factor Cα=.93 TRR= N/A	Not defined	-	The scale measures psychological insight after a psychedelic experience.
Coping Self-Insight Scale	(Crane et al. 2023)	27	Self-report	5 factors IR: Ranged between ω= .90-.96 TRR: N/A	Not defined	Time course of reactions Relationship between reactions Resilience capacity repertoire Stressors as growth opportunities Anticipated efficacy of resilient capacities	The scale assesses psychological insight into coping skills.

	Author(s) and Publication Year	**Item Counts**	**Type**	**Psychometric Properties***	**Target**	**Subscales/ Subdimensions**	**Additional information**
Cognitive Insight							
Yale-Brown Obsessive-Compulsive Scale	(Goodman et al. 1989) Turkish version: (Tek et al. 1995)	10 6 additional items	Clinician-rated	Cα=.89 TRR: .98	OCD and related disorders	Obsessions Compulsions	Item 11 assesses insight into beliefs about their thoughts.
Fixity of Beliefs Scale	(Foa and Kozak 1995)	5	Clinician-rated	N/A	OCD and related disorders	-	While 3 items of the scale evaluate cognitive insight, two items are for clinical insight.
Body Dysmorphic Disorder Examination	(Rosen and Reiter 1996)	28	Clinician-rated	Cα=.81 TRR= .87-.94	Both BDD and non-clinical population	-	Item 22 assesses the degree of conviction in physical defect.
Yale-Brown Obsessive-Compulsive Scale Modified for Body Dysmorphic Disorder	(Phillips et al. 1997) Turkish version: (Yücesoy et al. 2022)	12	Clinician-rated	3 factors	BDD	-	Item 11 assesses insight into appearance beliefs.
Brown Assessment of Beliefs Scale	(Eisen et al. 1998) Turkish Version: (Özcan et al. 2013)	7	Clinician rated	1 factor Cα=.87 TRR=.95	Mainly OCD and related disorders	-	While 6 items of the scale evaluate cognitive insight, one item is for clinical insight.
Overvalued Ideas Scale	(Neziroglu et al. 1999)	11	Clinician rated	Cα=.95 TRR=.93	OCD and related disorders	Stability of belief Three separate beliefs	While 10 items of the scale evaluate cognitive insight, one item is for clinical insight.
Beck Cognitive Insight Scale	(Beck et al. 2004) Turkish version: (Aslan et al. 2005)	15	Self-report	2 factors Cα=.68 (Self-reflectiveness); .60 (Self-certainty) TRR= N/A	Different clinical populations	Self-certainty Self-reflectiveness	The scale measures cognitive insight.
Insight Orientation Scale	(Gori et al. 2015)	7	Self-report	1 factor Cα=.77 TRR=N/A	Both general population and different clinical population	Level of consciousness Problem solving Restructuring Awareness Complexity (abstraction, depth) Surprise Self-reflectiveness-thoughtfulness	Several items were related to cognitive insight concept.
Nepean Belief Scale	(Brakoulias et al. 2018)	5	Clinician-rated	Cα=.87 TRR= .917	Mainly OCD and related disorders	Conviction Fixity Fluctuation Resistance Awareness that the belief is unreasonable	The scale assesses cognitive insight in terms of fixity and awareness of beliefs. Each item has its own target.
Clinical Insight							
Hamilton Depression Rating Scale	(Hamilton 1960) Turkish version:	17	Clinician-rated	4 factors Cα=N/A TRR=N/A	Both general population and	-	Item 17 assesses insight on a single dimension that whether the

	Author(s) and Publication Year	Item Counts	Type	Psychometric Properties*	Target	Subscales/ Subdimensions	Additional information
	(Akdemir et al. 2001)				different clinical population		patient acknowledges to being depressed and ill.
Positive and Negative Syndrome Scale Insight and Judgement items	(Kay et al. 1987) Turkish Version: (Kostakoğlu et al. 1999)	30	Clinician-rated	3 factors Cα=.73 (Positive); .83 (Negative); .79 (General psychopathology) TRR= .80 (Positive); .68 (Negative); .60 (General psychopathology)	Mainly schizophrenia spectrum disorders and other psychotic disorders	Positive Negative General Psychopathology	Item G12 assesses insight on a single dimension. The item provides a rating of the subject's awareness of his or her psychiatric symptoms, his or her need for treatment, and the consequences of the disorder.
Insight and Treatment Attitude Questionnaire	(McEvoy et al. 1989)	11	Clinician-rated	1 factor Cα=N/A TRR=N/A	Different clinical populations	-	It assesses insight into two dimensions. 6 items for awareness of illness and 5 items for attitudes towards treatment.
Markova's Insight Scale	1.Version Markova and Berrios (1992a) 2.Version (Marková et al. 2003) Turkish version: (Tüzer 1996)	First Version: 32 Second Version: 30	Both self-report and clinician rated	2 Factors (1. version) 4 factors (2. version) 1.version Cα= .71 (Group A); .55(Group B) TRR=N/A 2.version Cα=.875 TRR=.79	Different clinical populations	-	Both first and second version evaluate insight in terms of perception of being ill, general awareness of changes within self and the resulting difficulties in functioning, recognition of self-change and need for help, patients' recognition of changes in themselves and with the perception of change in their environment and their relationship with their environment and attitudes towards hospitalisation.
Schedule for Assessment of Insight/Expanded	(David et al. 1992) Expanded: (Kemp and David 1997) Turkish version: (Aslan et al. 2001)	8 Expanded:12	Clinician-rated	N/A (Original version) N/A (Expanded version)	Different clinical populations	Treatment compliance Recognition of illness Relabelling of psychotic phenomena	The scale assesses clinical insight in terms of recognition of illness, acceptance of treatment, relabelling of symptoms,

	Author(s) and Publication Year	Item Counts	Type	Psychometric Properties*	Target	Subscales/ Subdimensions	Additional information
						Hypothetical contradiction (Original version) Additional item exists in expanded version which are related to awareness of need for treatment, awareness of change in mental functioning, awareness of psychosocial consequences of the illness.	awareness of adverse consequences of the illness, awareness of symptoms, awareness of change in mental functioning.
Scale to Unawareness of Mental Disorder	(Amador et al. 1993) Turkish version: (Bora et al. 2006)	74	Clinician-rated	Cα=Not calculated TRR=N/A	Different clinical populations	Current awareness Current attribution Retrospective awareness Retrospective attribution General items (not included in the final score)	The scale assesses clinical insight in terms of awareness and attribution. Also, it has a time perspective about insight with evaluating current and retrospective insight.
Birchwood Insight Scale	(Birchwood et al. 1994) Turkish version: (Sakarya 2012)	8	Self-Report	3 factors Cα=.75 TRR=.90	Mainly psychotic disorders	Re-labelling symptoms Awareness of illness Need for treatment	The scale assesses clinical insight in terms of re-labelling symptoms, awareness and need for treatment.
Hanil Alcohol Insight Scale	(Kim et al. 1998)	20	Self-report	Cα=.89 TRR=.97	Alcohol use disorders	"whether or not the patient acknowledges his drinking problems" "whether or not he accepts his loss of control and/or he is alcohol dependent" "whether or not he has the intention to abstain" "whether or not he attributes his drinking to his environment and has empathy for the people seriously affected by his drinking" "whether or not he recognises the necessity of hospitalisation"	The scale was developed to measure insight in patients with alcohol dependence.
11-Item Insight Scale	(Wong et al. 1999)	11	Self-report	2 factors Cα=.74 TRR=N/A	Bipolar disorders	Need for treatment Perception of illness	The scale was adapted from Insight and Treatment

	Author(s) and Publication Year	**Item Counts**	**Type**	**Psychometric Properties***	**Target**	**Subscales/ Subdimensions**	**Additional information**
							Attitude Questionnaire and Explanatory Model Interview Catalogue.
Self-Appraisal of Illness Questionnaire	(Marks et al. 2000)	17	Self-report	3 factors Cα=.83 TRR=N/A	Mainly schizophrenia spectrum disorders	Need for treatment Worry Presence/outcome of illness	The scale assesses attitudes toward mental illness among persons receiving psychiatric treatment.
Psychosis Evaluation Tool for Common Use by Caregivers	(De Hert et al. 2002)	23	Clinician rated	N/A	Mainly schizophrenia spectrum disorders	Positive symptoms Negative symptoms Depressive symptoms Excitatory symptoms Cognitive symptoms	The scale was developed through PANSS and the G12 item (self-judgement and insight item) in PANSS is divided into two, i.e. self-judgement and insight are evaluated in two items.
Mood Disorders Insight Scale	(Sturman and Sproule 2003) Turkish version: (Konuk et al. 2007)	8 but there are additional question items for 3 items. Depending on whether the answer is yes or no, these additional items will be taken up.	Self-report	Cα=N/A TRR=.75	Mood disorders	Awareness of illness Attribution Need for treatment	It is a modified version of the Birchwood Insight Scale for mood disorders.
Measure of Insight into Cognition	SR:(Medalia et al. 2008) CR:(Medalia and Thysen 2008)	SR:12 CR:12	Both self-report and clinician-rated	Cα=.83(CR); .93 (SR) TRR=.92 (SR)	Schizophrenia spectrum disorders	For clinician rated: Awareness Attribution	The scale mainly focuses on awareness toward neurocognitive deficits in schizophrenia spectrum disorders.
Insight Scale for Affective Disorders	(Olaya et al. 2012)	17	Clinician rated	2 factos Cα=.88 TRR.87	Mood disorders	General Awareness	It is adapted from SMUD and the misattribution items in SMUD have been replaced by general items.
VAGUS Insight into Psychosis Scale	(Gerretsen et al. 2015) Turkish version: (Gundogmus et al. 2023)	VAGUS SR: 10 VAGUS CR: 5	VAGUS SR: self-report VAGUS CR: clinician rated	For VAGUS CR: 1 factor Cα=.74 TRR=.66 For VAGUS SR: 3 factors	Schizophrenia spectrum disorders and other psychotic disorders	For VAGUS CR: General illness awareness Awareness of need for treatment Awareness of negative consequences	The scales have the capacity to detect small, temporally sensitive changes in insight scores.

	Author(s) and Publication Year	Item Counts	Type	Psychometric Properties*	Target	Subscales/ Subdimensions	Additional information
				Cα=.77 TRR=.70		Symptoms attribution For VAGUS SR: General illness awareness Symptom attribution Awareness of need for treatment	
Signs and Symptoms of Psychotic Illness	(Liddle et al. 2002)	20	Clinician rated	5 factors Cα=N/A TRR=N/A	Schizophrenia spectrum disorders and other psychotic disorders	Anxiety/depression Psychomotor poverty Psychomotor excitation Disorganization Reality distortion	Item 20 assesses insight on a single dimension. The item provides a rating of the subject's awareness of his or her psychiatric symptoms.
Q8 Questionnaire	(Bourgeois et al. 2002) The original form is in French. English translation was conducted by Walvoort (2016)(Walvoort et al. 2016)	8	Self-report (However, clinician who knows the patient scores the scale with 0 or 1 for each item.)	1 factor** Cα=.73 TRR=N/A	Different clinical population	General illness awareness Awareness of need for treatment Awareness of negative consequences	While French version was developed severe mental disorders, English translation was conducted with alcohol dependency sample.
Schedule for the Assessment of Insight in Eating Disorder	(Konstantakopoulos et al. 2020)	8	Clinician-rated	Cα=.88 TRR=.89 (for anorexia nervosa sample); .92 (for bulimia nervosa sample)	Eating disorders	Relabelling of body weight concerns and eating pathology Hypothetical contradiction Recognition of body weight concerns and eating pathology Treatment engagement Recognition of mental illness Awareness of need for treatment	It has a similar structure to the SAI. It was developed to assess insight into eating disorder-specific illness and its consequences.
Alcohol Use Awareness and Insight Scale	(Kim et al. 2021)(Kim et al. 2021)	7	Self-report	1 factor Cα=.89 TRR=.84	Alcohol use disorders	-	Although questions were prepared for General Illness Awareness, Symptom Attribution, Awareness of Need for Treatment, Awareness of Negative Consequences, 1 factor emerged in the analyses.
Substance Use Awareness and Insight Scale	(Kim et al. 2022)	7	Self-report	2 factors Cα=.86 TRR=.87	Substance use disorders	-	Although questions were prepared for General Illness

	Author(s) and Publication Year	**Item Counts**	**Type**	**Psychometric Properties***	**Target**	**Subscales/ Subdimensions**	**Additional information**
							Awareness, Symptom Attribution, Awareness of Need for Treatment, Awareness of Negative Consequences, 2 factors emerged in the analyses.
Nicotine Use Awareness and Insight Scale	(Kim et al. 2022) Turkish version: (Muz et al. 2024)	7	Self-report	2 factors Cα=.78 TRR=.86	Nicotine addiction	-	Although questions were prepared for General Illness Awareness, Symptom Attribution, Awareness of Need for Treatment, Awareness of Negative Consequences, 2 factors emerged in the analyses.
Gambling Awareness and Insight Scale	(Kim et al. 2022)	8	Self-report	2 factors Cα=.80 TRR=.86	Gambling addiction disorder	-	Although questions were prepared for General Illness Awareness, Symptom Attribution, Awareness of Need for Treatment, Awareness of Negative Consequences, 2 factors emerged in the analyses.
Risk Insight Scale	(Hickman and Morris 2023)	14	Clinician-rated	2 factors Cα=.88 TRR=.90	Intellectual disabilities	Insight into offending and/or risky behaviours Insight into the need for treatment for offending and/or risky behaviours	This scale aims to assess the insight and understanding of individuals with intellectual disabilities (ID) who engage in offending and/or risky behaviours.
Psychotherapeutic Insight							
Session Impact Scale	(Elliott and Wexler 1994)	17	Clinician-rated	3 factors Cα=.67 (hindering impacts); .84 (task impacts); .91 (relationship impacts) TRR=N/A	Not defined	Helpful impacts -Task impacts -Relationship impacts Hindering impacts	It was developed to measure the effect of therapy sessions. 2 items assess psychological insight. The first item is the insight towards oneself, and the second item is the insight towards other people.

	Author(s) and Publication Year	Item Counts	Type	Psychometric Properties*	Target	Subscales/ Subdimensions	Additional information
Capacity for Dynamic Process Scale	(Baumann et al. 2001)	9	Clinician-rated	Cα=.83 (for therapist); .87 (for external rater) TRR=N/A	Not defined	Appears introspective Integrates affect, Manifest verbal fluency Manifest insight Perceive affective aspects of problems Differentiate affect Differentiate interpersonal event Offer positive relationship Collaborate therapeutically.	Although it is not a direct insight scale, two of its sub-dimensions assess psychotherapeutic insight.
Shedler-Westen Assessment Procedure (SWAP) Insight Scale	(Lehmann and Hilsenroth 2011)	6	Clinician rated	2 factors Cα=.78 TRR=N/A	Not defined	Positive/presence of insight Negative/absence of insight	The SWAP insight scale has been devolved from the SWAP 200 Q Sort clinical interview to measure psychological insight. The 6 items related to insight in the scale were taken.
Social Insight							
Social Insight Scale	(Chapin 1942)	25	Self-report	N/A	General population	Part I Part II	The scale assesses the social insight. Each question has a unique small story with social context and it is excepted from participants to choose best options according to them.
Buddhist Insight							
Ireland's Insight Scale	(Ireland 2013)	4	Self-report	1 factor Cα=.89 TRR=N/A	General population	Impermanent nature Suffering caused by attachment Conditional and relative nature Emptiness and/or oneness	It measures the insight that belongs to the Buddhist doctrine. Each item has its own perspective to evaluate the insight.
Mindfulness Insight Scale	(Jarukasemtha wee et al. 2024)	32	Self-report	3 factors Cα=.81 TRR=N/A	General population	Suffering Impermanence Interconnectedness	It measures the insight that belongs to the Buddhist doctrine.

Cα: Cronbach's α value, TRR: Test-retest reliability, IR: Internal reliability, N/A: Not available
*Results from original articles
**Results from English adaptation article conducted by Walvoort et al. (2016).

Psychological Insight

Names of the Scales

The first insight theme is psychological insight. For this purpose, 5 scales were defined: Psychological Insight Scale (Peill et al. 2022), Self-Reflection and Insight Scale (Grant et al. 2002), Coping Self-Insight Scale (Crane et

al. 2023), Psychological Insight Questionnaire (Davis et al. 2021), Insight Scale for Non-Clinical University Students (Akdoğan and Türküm 2018).

Definition and Examination of Scales

Psychological insight is broadly defined as the state of being aware of one's own feelings, thoughts and behaviour. In addition, various constructs have been defined for this type of insight, such as the degree of clarity in understanding one's own thoughts, feelings and behaviour, the awareness of internal states, and the capacity for introspection and self-examination (Conte et al. 1996, Grant et al. 2002, Sutton 2016). The first difficulty with this type of insight arises from the terms used above. The definition of insight includes terms such as self-awareness or introspection. Although Conte et al. (1996) stated that they were measuring 'psychological mindedness' in the scale they created, what is being assessed is closely related to psychological insight. Similarly, Sutton (2016) created a scale to measure self-awareness, but the definition of self-awareness is closely related to insight. These two scales were excluded since they were not directly related to insight. The second difficulty is that while some authors argue that this type of insight is situational, others, particularly in some studies of psychedelic use, argue that psychological insight emerges after exposure to these substances, i.e. they argue that it can be acquired acutely.

Starting with the trait of psychological insight, the concept of psychological insight used by Grant et al. in developing the Self-Reflection and Insight Scale can be conceptualised through the concept of self-consciousness (Grant et al. 2002). Fenigstein et al. proposed three types of self-consciousness: a) private self-consciousness, b) general self-consciousness, and c) social anxiety (Fenigstein et al. 1975). If we look at what self-consciousness is, it is the examination of one's behaviour by being aware of what is happening in one's inner world and one's feelings. While private self-consciousness relates to those aspects of the person that other people will not know, general self-consciousness is the awareness of other people's reactions and people's reactions to the person. Social anxiety is the anxiety felt during social communication, the state of feeling threatened by other people (Fenigstein et al. 1975).

Self-reflection, which is an aspect of private self-consciousness, is thinking about one's own feelings, thoughts, and behaviours, observing and evaluating oneself and improving oneself as a result (Grant et al. 2002). Grant went one step further and divided self-reflection into two types: a) individual-oriented self-reflection, b) solution-oriented self-reflection. While individual-oriented self-reflection focuses more on one's own thoughts, behaviours and emotions, solution-oriented self-reflection focuses more on the last part of the definition, i.e. self-improvement, in a sense, goal attainment (Grant et al. 2002). Although self-reflection seems to be a positive feature for the person with this definition, in cases where its level is high, it can lead the person to experience insecurity, anxiety and depressive symptoms (Grant et al. 2002).

Another aspect of private self-consciousness, insight, i.e. psychological insight, is being aware of one's feelings and thoughts, i.e. in a sense being aware of oneself. If we look at the definitions of self-reflection and insight, there are similarities. The common conclusion of the studies that attempt to differentiate the two concepts is that while self-reflection is a useful feature for the person up to a certain level, but at higher levels it leads to anxiety, depression and scepticism, whereas a high level of insight is a positive situation at all levels (Anderson et al. 1996, Creed and Funder 1998, Grant 2003). In explaining the difference between the two concepts, Roberts emphasised 'clear understanding'. Whereas self-reflection is the examination and evaluation of feelings, thoughts and behaviours, insight is the clear understanding of perceptions, behaviours, beliefs and feelings (Roberts and Stark 2008). Grant and colleagues developed the Self-Reflection and Insight Scale to assess self-reflection and insight, two aspects of self-consciousness (Grant et al. 2002). The SRIS has been widely used in studies on topics such as life coaching, performance improvement and academic success (Carr and Johnson 2013, Pai 2015). It asks participants to rate statements such as 'It is important for me to be able to understand how my thoughts come about', and 'It is often difficult for me to make sense of how I feel in the face of events'.

There are two scales that assess the development of psychological insight after the use of psychedelic substances: the Psychological Insight Scale and the Psychological Insight Questionnaire. Both scales assess a state of awareness or enlightenment that occurs after the use of psychoactive substances, i.e. insight into one's own feelings, thoughts and behaviours, and the connections and causalities between them. In the study in which the researchers developed the Psychological Insight Questionnaire, they claimed to measure acute experiences of psychological insight, defined as awareness or discoveries about personality, relationships, behaviours or emotions (Davis et al. 2021). The authors of the Psychological Insight Scale, on the other hand, criticised the Psychological Insight Questionnaire, stating that it assessed insight only in the acute period following the use of

psychedelic substances, and not in the sustained or long-term period. At the same time, they stated that the insight assessed by the Psychological Insight Questionnaire does not evaluate changes related to a time-limited experience (psychedelic substance use). In the scale they developed, they accepted insight as the emergence of a new perspective on oneself or one's life (Peill et al. 2022). In this article, both types of insight are classified as psychological insight, but they are considered to be an acute version of psychological insight.

The final type of insight that can be considered under the concept of psychological insight is coping self-insight. This concept is a specific form of insight that is important for the growth and improvement of the capacities that form the basis of resilience (i.e., coping resources, coping strategies, and adaptive beliefs. Coping insight is defined as an understanding of one's thoughts, feelings and behaviours in relation to the coping process (Crane et al. 2023). Before moving on to another theme of insight, a few words should be said about the concept of introspection. From the perspective of the structuralist model put forward by Wundt, understanding one's own psychological state can only be possible by using the introspective method (Radford 1974). Therefore, introspection is a close concept with insight. However, since this text focuses more on insight, the discussion on this concept is left here. Among these scales, only Self-Reflection and Insight Scale (Duysal and Çetin 2017) has Turkish reliability and validity study.

In summary, psychological insight is the state of awareness and understanding of one's own feelings, thoughts, beliefs, behaviours, personality, traits, and whatever else belongs to the self and the self's relationships with the environment.

Cognitive Insight

Names of the Scales

The second type of insight is cognitive insight. Nine scales have been defined in this context: Beck's Cognitive Insight Scale (Beck et al. 2004) and the Insight Orientation Scale (Gori et al. 2015), Yale-Brown Obsessive Compulsive Scale (Goodman et al. 1989), Brown Assessment of Beliefs Scale (Eisen et al. 1998), Overvalued Ideas Scale (Neziroglu et al. 1999), Fixity of Beliefs Scale (Foa and Kozak 1995), Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (Phillips et al. 1997), Nepean Belief Scale (Brakoulias et al. 2018), Body Dysmorphic Disorder Examination (Rosen and Reiter 1996).

Definition and Examination of Scales

If we first consider the cognitive insight proposed by Beck, he stated that insight is only meaningful when it descends from the intellectual level to the emotional level and suggested that the cognitive dimension was incomplete and proposed the concept of cognitive insight. Cognitive insight is the ability to evaluate one's own experience and cognition. The aim of cognitive insight is to focus on misinterpretations and distorted beliefs. In other words, in a sense, it targets the cognitive mechanisms that lead to psychotic symptoms (Van Camp et al. 2017). Beck and his team went one step further and developed a scale to assess cognitive insight(Beck et al. 2004). The Beck Cognitive Insight Scale was developed to improve understanding of patients' perspectives on their abnormal experiences, attributions, and deviant interpretations of certain life events. The cognitive insight proposed by Beck is divided into two: a) self-reflectiveness and b) self-certainty. Self-reflectiveness, which is part of cognitive insight, is the willingness to examine what one produces in one's mind. Self-certainty is overconfidence in the validity of one's own beliefs. Better cognitive insight is more self-reflectiveness and less self-certainty(Beck et al. 2004).

Another scale that can be used in psychotherapy is the Insight Orientation Scale (Gori et al. 2015). The aspects explored by the scale are surprising (making connections), restructuring (changeability, belief in a new meaning), level of awareness (ability to experience feelings), problem-solving (problem finding, problem shaping), complexity (abstraction, depth), self-reflection (thoughtfulness), awareness (attention, ability to perceive). This scale is presented here because it was compared with the Beck Cognitive Insight Scale in the study, but the authors also claim that it can be used in the psychotherapeutic field (Gori et al. 2015). Cognition and schemas are also included in the internal structure of the scale. Another item asks about the level of problem solving, which is why this scale is also included in the cognitive insight section. Gori et al. discussed that Beck's Cognitive Insight was inadequate and added other dimensions. The authors also stated that it can be used in the psychotherapeutic field, but it is more suitable for cognitive therapy methods such as Cognitive-Behavioural Therapy (CBT) and schema therapy (Gori et al. 2015). Cognitive insight refers to misinterpretations, erroneous beliefs or cognitive distortions arising from the person's situation (Beck et al. 2004). Thus, cognitive insight

involves not only the evaluation of erroneous beliefs and misinterpretations but also their correction. Therefore, cognitive insight can be not only a tool for therapeutic improvement but also a therapeutic goal. Consequently, cognitive insight may be considered an important indicator of functioning in psychotic or relatively more severely mentally ill patients.

It is necessary to pay attention to the scales that are intended to assess insight into OCD and related disorders. This is because self-certainty, which is a part of cognitive insight, could be considered both a part of insight and a symptom. In OCD, it is important to assess how certain patients are about their beliefs. The Yale-Brown Obsessive-Compulsive Scale has an item (item 11) that assesses insight. This item assesses awareness of the illness, which is a component of clinical insight, but it does so by asking how reasonable the patient thinks their thoughts are (Goodman et al. 1989). I prefer to include the Yale-Brown Obsessive-Compulsive Scale in cognitive insight. In addition, there is an adapted version of the Yale Brwon Obsessive Compulsive Scale designed to assess body dysmorphic disorder. This scale has 12 items and one of them assesses insight into appearance beliefs, that is, cognitive insight (Phillips et al. 1997). The other scale is the Brown Assessments of Beliefs Scale. This scale has 7 items and while six of them assess how convinced or certain patients are about their beliefs, which indicates the self-confidence part of cognitive insight, the other item is more related to clinical insight. Although the research team that developed the scale conducted their study in patients with OCD and related disorders, they indicated that the scale could be used for other psychiatric disorders, such as schizophrenia (Eisen et al. 1998). The Overvalued Ideas Scale is another scale that focuses mainly on cognitive insight. The scale consists of 11 items and while ten of them are related to cognitive insight, the other one is an assessment of illness awareness, and it was developed for OCD (Neziroglu et al. 1999). The Fixity of Beliefs Scale is the last scale developed to assess the degree of fixity of beliefs in patients with OCD (Foa and Kozak 1995). This scale consists of five items, three of which are related to cognitive insight and two of which are related to clinical insight. These three scales show a need to define beliefs and overvalued ideas, and a concept emerges from beliefs and overvalued ideas, which is delusionality. Delusionality was considered because it is specific to delusional disorders such as schizophrenia and is dichotomous. However, several disorders, such as obsessive-compulsive disorder and body dysmorphic disorder, could have some degree of delusional thinking. Therefore, delusionality is now seen as a continuum between explicit delusions at one end and rational thoughts at the other. Overvalued thoughts are those that fall between these two extremes. Considering the symptomatology of OCD and related disorders, the degree to which they believe their thoughts are rational varies (Eisen et al. 1998). This question brings us to insight into OCD and related disorders. Because insight in these disorders means that they can see how false, changeable or irrational their thoughts or beliefs are, which brings us to the concept of self-certainty, which is part of cognitive insight.

It is important to stress the difference between cognitive and clinical insight. Whereas clinical insight is mainly concerned with awareness of the illness, cognitive insight is more concerned with the ability to evaluate thoughts. However, Beck's concept of cognitive insight does not seem to fully match the concept of insight assessed in OCD and related disorders. Although the concept of self-certainty includes the fallibility of thought, it does not fully match the assessment of insight in terms of delusionality, overvalued ideas or beliefs assessed in OCD. Among these scales, Yale-Brown Obsessive-Compulsive Scale (Tek et al. 1995), Yale-Brown Obsessive-Compulsive Scale Modified for Body Dysmorphic Disorder (YÜCESOY et al. 2022) , Beck Cognitive Insight Scale (Aslan et al. 2005) , Brown Assessment of Belief Scale (Özcan et al. 2013) have Turkish validity and reliability study.

In summary, cognitive insight assesses how inclined and intentional the person is to reflect on the cognitions they hold and at the same time how firmly they hold on to their beliefs and cognitions and how much they believe in their accuracy. In addition, skills such as problem-solving, the ability to change beliefs and the ability to perceive can also be considered in the context of this insight.

Clinical Insight

Names of the Scales

The third insight is clinical insight and 23 scales were identified in this field: Birchwood Insight Scale (Birchwood et al. 1994), VAGUS Insight into Psychosis Scale (Gerretsen et al. 2014), Markova's Insight Scale (Marková et al. 2003), Insight Scale for Affective Disorders (Olaya et al. 2012), Mood Disorders Insight Scale (Sturman and Sproule 2003), Substance Use Awareness and Insight Scale (Kim et al. 2022), Nicotine Use Awareness and Insight Scale (Kim et al. 2022), Gambling Awareness and Insight Scale (Kim et al. 2022), Alcohol Use Awareness and Insight Scale (Kim et al. 2021), Schedule for Assessment of Insight/Expanded (Kemp and David 1997), Scale to

Unawareness of Mental Disorder (Amador and Gorman 1998), Signs and Symptoms of Psychotic Illness (Liddle et al. 2002), Hanil Alcohol Insight Scale (Kim et al. 1998), Self-Appraisal of Illness Questionnaire (Marks et al. 2000), Positive and Negative Syndrome Scale Insight and Judgement items (Kay et al. 1987), Schedule for the Assessment of Insight in Eating Disorder (Konstantakopoulos et al. 2020), Insight and Treatment Attitude Questionnaire (McEvoy et al. 1989), Psychosis Evaluation Tool for Common Use by Caregivers (De Hert et al. 2002), Risk Insight Scale (Hickman and Morris 2023), Hamilton Depression Rating Scale (HAMILTON 1960), 11-Item Insight Scale (Wong et al. 1999), Measure of Insight into Cognition Self-Report/Clinician-Rated (Medalia and Thysen 2008, Medalia et al. 2008), Q8 Questionnaire(Bourgeois et al. 2002, Walvoort et al. 2016).

Definition and Examination of Scales

Jaspers defined insight as awareness of one's illness and symptoms, and it was thought that its absence, especially in psychotic patients, distinguished this group of patients from neurotic patients (Jaspers 1968). It was later recognised that this dichotomy was invalid. As with psychosis, it has been suggested that insight is a continuum (Amador and David 1999). The concept of clinical insight has been addressed through the weak or inadequate insight into the illness observed in psychotic patients. In schizophrenia or other psychotic disorders, patients believe that the symptoms they experience are not caused by their illness. However, this is only one dimension of clinical insight. In the early period, clinical insight, which was treated as present-absent, became multidimensional and began to be treated as a spectrum with the contributions of David and Amador (1999) in the following periods.

Insight has been defined by David (1990) as consisting of three constructs: (1) the ability to re-label certain mental events as pathological, (2) the patient's recognition that he/she has a mental disorder, and (3) seeking or complying with treatment (David 1990).

Amador's insight has two basic dimensions and two-time dimensions (Amador and Gorman 1998). The basic dimensions are awareness and attribution, and the time dimension is current and retrospective. Awareness refers to the recognition of signs or symptoms of illness, while attribution refers to the source or explanation of these signs or symptoms. Current refers to the awareness and attribution of existing symptoms, whereas retrospective refers to the awareness and attribution of symptoms that, for example, a patient who has been in hospital for some time has during the period after discharge. In this perspective, Amador and Gorman (1998) described four dimensions of clinical insight, sometimes referred to as insight into illness, which together address awareness and attribution: (I) awareness or acceptance of illness, (ii) awareness of symptoms and accurate symptom attribution, (iii) awareness of the need for treatment, and (iv) awareness of negative consequences of illness (e.g., arrest, hospitalisation, interpersonal or occupational dysfunction, etc.).

Some scales (e.g. Birchwood Insight Scale, Mood Disorders Insight Scale) assess three of these four dimensions, i.e. as presented by David, while others address all four dimensions (VAGUS Self-report/Clinician-Rated, Scale to Unawareness of Mental Disorder). The older scales developed by Markova and colleagues were limited to two dimensions: the patient's self-knowledge of their illness and how it might affect their ability to function and interact with the environment (Marková et al. 2003).

Insight into illness has been described as having both 'trait' and 'state' characteristics (Wiffen et al. 2010). Longitudinal studies suggest that insight tends to be stable or gradually improving during the maintenance phase of schizophrenia (Cuesta et al. 2000, Wiffen et al. 2010), while other research suggests that insight may fluctuate with relapses and the resolution of acute, primarily positive symptoms (Weiler et al. 2000, Mintz et al. 2003).

While most scales assessing clinical insight are used for psychotic disorders, Olaya et al. developed a scale for mood disorders by adapting Amador's scale. The main difference from the other scale is that general items were included instead of the misattribution subscale. As a result, it consists of general items and awareness items (Olaya et al. 2012). Another borrowed scale is the Mood Disorders Insight Scale (Sturman and Sproule 2003). This scale, adapted from the Birchwood Insight Scale, was developed to assess clinical insight in mood disorders, as proposed by David. It also scores on three sub-dimensions, but unlike the Birchwood Insight Scale, it also allows for retrospective scoring. Item 17 of the Hamilton Depression Rating Scale, which is often used by clinicians to assess depression, assesses clinical insight by asking whether the person accepts that they are ill (Hamilton 1960).

Lack of insight into having a mental disorder is an important indicator of poorer psychosocial outcomes, clinical outcomes, treatment compliance, frontal and parietal grey matter volume, and suicidal behaviour in patients with severe mental disorders. Although most of the literature on insight has focused on schizophrenia, there is

evidence that insight is also impaired in mood disorders and may play a role in treatment compliance and outcome (Olaya et al. 2012).

Several scales under this type of insight are not directly related to the assessment of insight. They have a single item for insight, such as Signs and Symptoms of Psychotic Illness (Liddle et al. 2002), Positive and Negative Syndrome Scale Insight and Judgement items (Kay et al. 1987). In both two scales, the awareness of illness is evaluated.

While most of the scales evaluating clinical insight in schizophrenia focus on the positive and negative symptoms, the Measure of Insight into Cognition Self-Report/Clinician-Rated scale has a different focus which is awareness of neurocognitive deficits in schizophrenia spectrum disorders (Medalia and Thysen 2008, Medalia et al. 2008).

Some of the scales assessing clinical insight are specific to the disorder. These include the scales created by Kim and colleagues, which address substance (Kim et al. 2022), alcohol(Kim et al. 2021), nicotine(Kim et al. 2022) and gambling (Kim et al. 2022) addiction with 4 dimensions of clinical insight. Another scale for alcohol dependence is the Hanil Alcohol Insight Scale (Kim et al. 1998). Developed by Kim and colleagues, it measures insight into alcohol dependence in 5 subcategories. Another disorder-specific insight scale is the Schedule for the Assessment of Insight in Eating Disorder, which was developed based on the model proposed by David and Amador and is similar in structure to the Schedule for the Assessment of Insight (Konstantakopoulos et al. 2020). Similarly, insight addresses re-labelling through body concerns and eating pathology, and also asks about treatment compliance and needs.

Another insight that can be provided under this heading is the insight assessed by the Risk Insight Scale. This measure aims to assess the insight and understanding of people with intellectual disabilities (ID) who offend and/or engage in risky behaviour. The measure assesses insight in two domains: insight into offending and/or risky behaviour and insight into the need for treatment for offending and/or risky behaviour (Hickman and Morris 2023).

Among these scales, Hamilton Depression Rating Scale (Akdemir et al. 2001), Positive and Negative Syndrome Scale (Kostakoğlu et al. 1999), Schedule for Assessment of Insight (ASLAN et al. 2001), Markova Insight Scale (Tüzer 1996), Scale to Unawareness of Mental Disorder (Bora et al. 2006), Birchwood Insight Scale (Sakarya 2012), Mood Disorders Insight Scale (Konuk et al. 2007), VAGUS-CR and SR (Gundogmus et al. 2023), Nicotine Use Awareness and Insight Scale (Muz et al. 2024) have Turkish validity and reliability study.

In summary, clinical insight aims to assess awareness of the illness, the importance of the symptoms and awareness of the cost of the illness. Although it was first assessed in psychotic disorders, in the following years it was found to be important in other psychiatric disorders as well.

Psychotherapeutic Insight

Names of the Scales

The fourth type of insight is psychotherapeutic insight. Three scales were determined in this direction: Shedler-Westen Assessment Procedure (SWAP) Insight Scale (Lehmann and Hilsenroth 2011), Capacity for Dynamic Process Scale (Baumann et al. 2001), Session Impact Scale (Elliott and Wexler 1994).

Definition and Examination of Scales

Although they are categorised as psychotherapeutic insights, they actually express an insight that emerges during the psychodynamic therapy process and influences the therapy process. The purpose of specifying this type of insight separately is that it is most often manifested in psychodynamic psychotherapy. One of the ultimate goals of therapy is to help people gain insight into their relationship with themselves and what is happening around them, and there is a type of therapy in that area called insight-oriented psychodynamic psychotherapy. Psychological insight is an insight that is the product of mental actions that can be measured by empirical models. Therefore, it cannot be empirically proven. However, it can be assessed by some clinicians using interview-based techniques.

The concept of a patient's intrinsic capacity to engage in a psychotherapeutic process was first articulated by Freud (1905) in his discussion of analysability(Freud 1905). Freud (1905) recognised early on that certain patient characteristics are important factors in promoting different forms of psychological development and

influence both treatment and outcome (p. 108). Some also see insight as a measure of one's ability to understand the mental states of others and do not include self-awareness in their definition (Piper et al. 1994, Conte et al. 1996). In addition, Fonagy defined the dimensions of insight in the concept of reflective self-functioning as awareness of one's own and others' mental states. More specifically, insight is defined as a progressive ability to understand that human behaviour is regulated by thoughts, feelings, desires, and beliefs, each of which is related to self and others (Fonagy and Target 2003).

Psychotherapeutic insight is the development of self-understanding and awareness during the therapy process and is one of the main goals of therapy. Messer defined the characteristics of therapeutic insight as a) recognising patterns and connections, b) observing personality and internal processes, examining abnormal thoughts, recognising one's own motivations, and recognising the motivations of others (Messer and McWilliams, 2007). Many studies have successfully operationalised insight in an attempt to understand its development, causes and implications for the therapeutic process. Luborsky and colleagues (1988) examined patients' core conflictual relationship themes collected by independent raters to assess patients' expression of insight in session. The results indicated that the patient's level of understanding was significantly correlated with treatment outcome (Luborsky et al. 1988). Several studies have also examined whether patient insight is an increasing outcome criterion over the course of treatment. One study found that levels of self-awareness increased during psychotherapy (Vargas 1954). These studies support the role of insight in the psychotherapeutic process and development. Based on these findings, it may be that a patient's capacity for insight enables them to engage more fully in treatment. These studies support the role of insight in the psychotherapeutic process and development.

Some authors have considered psychological insight to be the conscious awareness of stressors rather than the awareness or clear understanding of feelings, thoughts and behaviours in general (Kivlighan et al. 2000). For example, Kivlighan et al (2000) found that insight, defined as the conscious awareness of thoughts and feelings contributing to distress, increased over 20 psychoanalytic psychotherapy sessions. Insight was associated with favourable outcomes in an 'antecedent-follower' relationship (i.e. reductions in target distress often preceded and were proportional to increases in insight).

Shedler-Westen Assessment Procedure Insight Scale, what is needed beyond these well-established existing instruments is a scale that measures patients' levels of insight within their personality constructs, rather than a scale that measures insight within the therapeutic process (Lehmann and Hilsenroth 2011). The original Shedler-Westen Assessment Procedure, the Shedler-Westen Assessment Procedure Q-Sort (SWAP-200), is such a measure and is widely used as a diagnostic tool for personality assessment through detailed patient reports of observable behaviours and interpersonal interactions. Although the creators of the Shedler-Westen Assessment Procedure Insight claim that what they are measuring is psychological insight, what they are talking about is an insight that is active in the psychotherapeutic process. This is because in their studies they also evaluated the in-session video recordings. At the same time, they claim that in their studies they make an assessment of insight independent of functionality.

Although the Capacity for Dynamic Process Scale is not a direct measure of insight, it does address insight from a psychodynamic perspective (Baumann et al. 2001). Its two dimensions are actually related to the concept of insight. The seemingly introspective subscale refers to being in a state of interest and effort to understand internal events, while the manifest insight subscale assesses the ability to identify and understand salient information about oneself and others. Dynamic process capacity may be more related to the capacity for the affective, interpersonal and insight focus of dynamic therapy than to the patient's ability to cooperate. Because low levels of capacity for dynamic processes were also associated with early termination, and low therapeutic alliance. Therefore, it is more the psychotherapeutic process that is assessed.

In the Season Impact scale, insight is addressed in two items. In the first item the client is asked whether he/she has an insight or has learned something new about himself/herself as a result of the session (Elliott and Wexler 1994). This is in the form of a new connection or understanding of why they feel the way they do. The second item asks about understanding or developing a new insight about other people or insight about people in general.

In summary, psychotherapeutic insight is a different kind of insight from psychological insight. Rather, and especially for psychodynamic therapies, it is a type of insight that can be related to the patient's therapeutic rapport, in which the patient's awareness of himself or herself and the relationship he or she establishes with his or her environment during the sessions and, in a sense, enlightenment. Although it is claimed that it can increase with the therapy process, its level before therapy begins predicts the therapy process.

Social Insight

Names of the Scales

The fifth type of insight is social insight. A scale has been defined to measure this insight: Social Insight Scale (Chapin 1942).

Definition and Examination of Scale

Social insight basically consists of two dimensions: a) the existence and functioning of defences such as projection, rationalisation, regression, sublimation, and transference in the social context, and b) insight into the use of humour, compromise, avoidance of embarrassment and status protection to reduce group conflict and tension, to find the right thought pattern or formula to solve the problem (Chapin 1942). The aim of the Social Insight Scale, as formulated by Chapin, is to measure the ability to identify, in any given situation, (a) the psychological dynamics underlying a particular attitude, and (b) the impulses, compromises or innovations necessary to resolve or constructively conclude the situation. Chapin stressed that the ability to make these assessments is not the same as the ability to get along or interact harmoniously with people; in other words, Chapin's formulation stresses the individual's diagnostic capacity, not the individual's tendencies towards more or less harmonious behaviour.

Buddhist Insight

Names of the Scales

The last insight is Buddhist insight, a type of insight that is not found in the field of psychiatry but is expressed especially in the fields of mindfulness and psychology related to Eastern philosophy. Two scales have been defined in this sense: the Mindfulness Insight Scale (Jarukasemthawee et al. 2024), Ireland's Insight Scale (Ireland 2013).

Definition and Examination of Scales

The "three characteristics of existence" are an integral part of traditional Buddhist mindfulness practice in the search for insight. These characteristics are suffering ('dukkha'), impermanence ('anicca') and the disconnection or emptiness of the self ('anatta'). Suffering refers to physical pain, the inevitability of injury, sickness, ageing and death, and psychological distress arising from the conflict between impermanence and the unsatisfactoriness of desire. Impermanence emphasises the transitory nature of all phenomena, including the human life cycle from birth to death. The flow of human consciousness is made up of fleeting moments that shape the constructed reality of the mind. Connectedness challenges the notion of a separate self (also called the emptiness of the self) and emphasises the interconnectedness of all things. In the Buddhist tradition, the practice of mindfulness is integrated with the development of insight into the three characteristics of existence. Mindfulness practice can be structured in ways that attempt to enhance the gain of insight. For example, practitioners can engage in mindfulness of breathing, where they observe their preferred breathing style and become aware of their efforts to change their breathing. This experience reflects an initial insight into the inevitability of suffering as one strives to change one's experience of the world. Practitioners also become aware of the second insight, impermanence, by experiencing the ever-changing nature of the breath. Over time, they may find that the breath continues naturally without their intervention, leading to the third insight of the interconnectedness of all things and the emptiness of the self (Grabovac et al. 2011, Ireland 2013, Jarukasemthawee et al. 2024).

Discussion

This paper reviews the scales used to assess insight in both general and clinical populations and provides a conceptualisation through a review of the scales used to assess insight. Insight is a multifaceted and complex concept that has both clinical significance and an understanding of the human relationship with self and others. Clinically, insight has several dimensions, such as awareness of the illness, relabelling of symptoms, awareness of the need for treatment, and awareness of consequences of illness (David 1990, Amador et al. 1993, Kemp ve David 1997, Amador and Gorman 1998, Amador and David 1999) while it also has other dimensions, such as

awareness of one's own thoughts, beliefs, behaviours, emotions(Feningstein et al. 1975, Feningstein 1984, Eisen et al. 1998, Neziroglu et al. 1999, Grant et al. 2002, Beck et al. 2004). Furthermore, insight is not only about being aware of what is counted above, but also about being convinced that it is true or valid or unfalsifiable, and about being able to reflect on it (Beck et al. 2004). There are also two different types of insight that have little place in psychology and psychiatry, namely social insight and Buddhist insight. These two types of insight bring to the construct of insight a social context (Chapin 1942) and introspection or insight that is the aim of Buddhist or mindfulness practice (Grabovac et al. 2011, Jarukasemthawee et al. 2024). Given this brief description of insight, it is not difficult to acknowledge how complex insight is.

This complexity is reflected in the development of scales. There is no scale that assesses every facet of insight. Researchers have approached insight and developed a scale in harmony with their own insight perspective. Another challenge in developing a scale may be that there are several concepts related to insight, such as overvalued ideas or beliefs. These concepts mainly belong to OCD and related disorders, and they seem to be close to both clinical and cognitive insight, that's because we could see that the scales assessing overvalued ideas or beliefs have questions related to both cognitive and clinical insight (Eisen et al. 1998, Neziroglu et al. 1999).

This paper has several limitations. First, the research strategy focused mainly on 'insight'. Therefore, scales assessing self-awareness, introspection or self-consciousness were excluded. Secondly, psychometric properties and target populations could not be obtained from the original articles. Although there are studies conducted by researchers other than developers and some of these studies could provide psychometric properties, they were not included in this study. Thirdly, only Cronbach alpha, number of factors, number of items, test-retest reliability and subscale/subdimensions of scales were presented. Presenting more detailed information about scales could be beneficial, but it was thought that presenting more information would make the paper more complex for readers. However, references were given to the original articles of the scales so that readers could access more detailed information from there. Fourth, some scales contain items related to different insight themes. Nevertheless, it is presented how many items in the scale are related to which insight theme. Fifth, some insight themes overlap, such as psychological insight and psychotherapeutic insight, or cognitive insight and clinical insight. However, there are some nuances presented in each insight sub-heading.

Conclusion

Insight is a complex and unique construct that is both confusing and comprehensive in its identification. Although there is a wealth of work on insight in the literature, there is still a long way to go to elucidate this concept. It is imperative that insight, like other psychiatric phenomena, be treated dimensionally rather than categorically. Today, in the light of the scales still under review, insight is most often thought of as a spectrum. However, insight is not just a spectrum, but a psychological concept that is a combination of more than one spectrum, i.e. a psychological concept with dimensions. When developing scales, it may not always be possible to include all the dimensions together, but researchers need to know which dimensions they are measuring and which they are excluding when measuring insight. Otherwise, when patients are said to have good insight, they are only referring to a state of well-being that is observed or rated in the dimension being measured.

References

Akdemir A, Türkçapar MH, Örsel SD, Demirergi N, Dag I, Özbay MH (2001) Reliability and validity of the Turkish version of the Hamilton depression rating scale. Compr Psychiatry, 42:161-165.

Akdoğan R, Türküm AS (2018) Insight scale for nonclinical university students: validity and reliability analysis. Meas Eval Couns Dev, 51:250-262.

Amador XF, David AS (1999) Insight and psychosis. Nord J Psychiatry, 53:467–468.

Amador XF, Gorman JM (1998) Psychopathologic domains and insight in schizophrenia. Psychiatr Clin North Am, 21: 27-42.

Amador XF, Strauss DH, Yale SA, Flaum MM, Endicott J, Gorman JM (1993) Assessment of insight in psychosis. Am J Psychiatry, 150:873-879.

Anderson RM, Bohon LM, Berrigan LP (1996) Factor structure of the private self-consciousness scale. J Pers Assess, 66:144-152.

Aslan S, Karakılıç H, Işıklı S, Coşar B, Işık E (2001) İçgörünün üç bileşenini değerlendirme ölçeği: güvenirlik ve geçerlik çalışması. Türkiye'de Psikiyatri Dergisi, 3:17-24.

Aslan S, Turkcapar H, Guney E, Eren N, Akkoca Y, Ugurlu M et al. (2005) Beck Bilişsel İçgörü Ölçeği Türkçe formunun şizofrenik Hastalar için güvenilirlik ve geçerlik çalışması. Klinik Psikiyatri Dergisi, 8:186-196.

Baumann BD, Mount MK, Holdwick DJ, Hilsenroth MJ, Ackerman SJ, Baity MR et al. (2001) The capacity for dynamic process scale: an examination of reliability, validity, and relation to therapeutic alliance. Psychother Res, 11:275-294.

Beck AT, Baruch E, Balter JM, Steer RA (2004) A new instrument for measuring insight: the Beck cognitive insight scale. Schizophr Res, 68:319-329.

Birchwood M, Smith J, Drury V, Healy J, Macmillan F, Slade M (1994) A self-report insight scale for psychosis: reliability, validity and sensitivity to change. Acta Psychiatr Scand, 89:62-67.

Bora E, Ozdemir F, Ozaskinli S (2006) The reliability and validity of the abbreviated version scale of unawareness to mental disorder. Türkiye'de Psikiyatri Dergisi, 8:74–80.

Bourgeois ML, Koleck M, Jais E (2002) Validation of the insight Q8 scale and evaluation of the awareness of disorder in 121 psychiatric inpatients. Annales Medico-Psychologiques 160:512-517.

Brakoulias V, Starcevic V, Milicevic D, Hannan A, Viswasam K, Brown C (2018) The Nepean belief scale: preliminary reliability and validity in obsessive–compulsive disorder. Int J Psychiatry Clin Pract, 22:84-88.

Van Camp LSC, Sabbe BGC, Oldenburg JFE (2017) Cognitive insight: a systematic review. Clin Psychol Rev, 55:12-24.

Carr SE, Johnson PH (2013) Does self reflection and insight correlate with academic performance in medical students? BMC Med Educ, 13:1-5.

Chapin FS (1942) Preliminary standardization of a social insight scale. Am Sociol Rev, 7:214-225.

Conte HR, Ratto R, Karasu TB (1996) The psychological mindedness scale: factor structure and relationship to outcome of psychotherapy. J Psychother Pract Res, 5:250-259.

Crane MF, Hoare S, Kangas M, Gucciardi DF, Karin E (2023) A coping self-insight scale for adults: development and preliminary psychometric properties. Anxiety Stress Coping, 37:1–23.

Creed AT, Funder DC (1998) The two faces of private self-consciousness: self report, peer-report, and behavioral correlates. Eur J Pers, 12:411-431.

Cuesta MJ, Peralta V, Zarzueal A (2000) Reappraising insight in psychosis. Br J Psychiatry, 177:233-240.

David A, Buchanan A, Reed A, Almeida O (1992) The assessment of insight in psychosis. Br J Psychiatry, 161:599-602.

David AS (1990) Insight and psychosis. Br J Psychiatry, 156:798-808.

Davis AK, Barrett FS, So S, Gukasyan N, Swift TC, Griffiths RR (2021) Development of the psychological insight questionnaire among a sample of people who have consumed psitlocybin or LSD. J Psychopharmacol, 35:437-446.

Duysal A, Çetin F (2017) Turkish version of self-reflection and insight scale: a preliminary study for validity and reliability of the constructs. Psychol Stud, 62:21-24.

Eisen JL, Phillips KA, Baer L, Beer DA, Atala KD, Rasmussen SA (1998) The Brown assessment of beliefs scale: reliability and validity. Am J Psychiatry, 155:102-108.

Elliott R, Wexler MM (1994) Measuring the impact of sessions in process-experiential therapy of depression: the session impacts scale. J Couns Psychol, 41:166-174.

Fenigstein A (1984) Self-consciousness and the overperception of self as a target. J Pers Soc Psychol, 47:860-870.

Fenigstein A, Scheier MF, Buss AH (1975) Public and private self-consciousness: assessment and theory. J Consult Clin Psychol, 43:522-527.

Foa EB, Kozak MJ (1995) DSM-IV field trial: obsessive-compulsive disorder. Am J Psychiatry, 152:90-96.

Fonagy P, Targer M (2003) Evolution of the interpersonal interpretive function: clues for effective preventive intervention in early childhood. In September 11: Trauma and human bonds (Eds SW Coates, JL Rosenthal, DS Schechter):900–1113. New Jersey, Analytic Press.

Freud S (1905) Fragment of an Analysis of a Case of Hysteria. In The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol VII (Ed J Strachey):1–122. London, Hogarth Press.

Gerretsen P, Flint AJ, Whyte EM, Rothschild AJ, Meyers BS, Mulsant BH (2015) Impaired insight into delusions predicts treatment outcome during a randomized controlled trial for psychotic depression (STOP-PD Study). J Clin Psychiatry, 76:427-433.

Gerretsen P, Remington G, Borlido C, Quilty L, Hassan S, Polsinelli G et al. (2014) The VAGUS insight into psychosis scale--self-report and clinician-rated versions. Psychiatry Res, 220:1084-1089.

Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL et al. (1989) The Yale-Brown obsessive compulsive scale: I. development, use, and reliability. Arch Gen Psychiatry, 46:1006-1011.

Gori A, Craparo G, Giannini M, Loscalzo Y, Caretti V, La Barbera D et al. (2015) Development of a new measure for assessing insight: psychometric properties of the insight orientation scale (IOS). Schizophr Res, 169:298-302.

Grabovac AD, Lau MA, Willett BR (2011) Mechanisms of mindfulness: a Buddhist psychological model. Mindfulness, 2:154–66.

Grant AM (2003) The impact of life coaching on goal attainment, metacognition and mental health. Soc Behav Pers, 31:253-263.

Grant AM, Franklin J, Langford P (2002) The self-reflection and insight scale: a new measure of private self-consciousness. Soc Behav Pers, 30:821-835.

Gundogmus AG, Gerretsen P, Song J, Erdi Akdag F, Demirel C, Kokurcan A et al. (2023) Insight in schizophrenia is associated with psychoeducation and social support: testing a new more comprehensive insight tool in Turkish schizophrenia patients. PLoS One, 18:e0288177.

Hamilton M (1960) A rating scale for depression. J Neurol Neurosurg Psychiatry Res, 23:56-62.

Hert MD, Wampers M, Thys E, Wieselgren IM, Linström E, Peuskens J (2002) Validation study of PECC (Psychosis Evaluation Tool for Common Use by Caregivers): interscale validity and inter-rater reliability. Int J Psychiatry Clin Pract, 6:135-140.

Hickman G, Morris A (2023) A pilot study assessing initial psychometric properties of 'the Risk Insight Scale.' Journal of Forensic Practice, 25:12-21.

Ireland MJ (2013) Meditative insight: conceptual and measurement development. Ment Health Relig Cult, 16:79–99.

Jarukasemthawee S, Halford WK, Fox A, Smith L, Pisitsungkagarn K, Trower P et al. (2024) Development and validation of the Mindfulness Insight Scale. Pers Individ Dif, 216:1-12.

Jaspers K (1968) The phenomenological approach in psychopathology. Br J Psychiatry, 114:1313-1323.

Kay SR, Fiszbein A, Opler LA (1987) The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophr Bull, 13:261–276.

Kemp RA, David AS (1997) Insight and compliance in treatment compliance and the therapeutic alliance. Br Med J, 54:222-227.

Kim JS, Kim GJ, Lee JM, Lee CS, Oh JK (1998) HAIS (Hanil Alcohol Insight Scale): validation of an insight-evaluation instrument for practical use in alcoholism. J Stud Alcohol, 59:52–55.

Kim J, Amaev A, Quilty LC, Selby P, Shah P, Caravaggio F et al. (2022) A measure to assess illness awareness in problem gambling: gambling awareness and insight scale (GAS).

J Gambl Stud, 38:1029-1043.

Kim J, Kambari Y, Taggar A, Quilty LC, Selby P, Caravaggio F et al. (2022) A measure of illness awareness in individuals with nicotine dependence-nicotine use awareness and insight scale. Nicotine Tob Res, 24:536-543.

Kim J, Kambari Y, Taggar A, Quilty LC, Selby P, Caravaggio F et al. (2022). A measure of subjective substance use disorder awareness – substance use awareness and insight scale (SAS). Drug Alcohol Depend, 231:e109129.

Kim J, Taggar A, Quilty LC, Selby P, Caravaggio F, Ueno F et al. (2021) A measure of illness awareness in alcohol use disorder—alcohol use awareness and insight scale (AAS). Drug Alcohol Depend, 226:e108813.

Kivlighan DM, Multon KD, Patton MJ (2000) Insight and symptom reduction in time-limited psychoanalytic counseling. J Couns Psychol, 47:50-58.

Konstantakopoulos G, Georgantopoulos G, Gonidakis F, Michopoulos I, Stefanatou P, David AS (2020) Development and validation of the schedule for the assessment of insight in eating disorders (SAI-ED). Psychiatry Res, 292:e113308.

Konuk N, Kiran S, Tamam L, Karaahmet L, Aydin H, Atik L (2007) Validation of the Turkish version of the mood disorder questionnaire for screening bipolar disorders. Turk Psikiyatri Derg, 18:147-154.

Kostakoğlu AE, Batur S, Tiryaki A, Göğüş A (1999) Pozitif ve negatif sendrom ölçeğinin (PANSS) Türkçe uyarlamasının geçerlilik ve güvenilirliği. Türk Psikoloji Dergisi, 14:23–32.

Lehmann MF, Hilsenroth MJ (2011) Evaluating psychological insight in a clinical sample using the Shedler-Westen assessment procedure. J Nerv Ment Dis, 199:354-359.

Liddle PF, Ngan ETC, Duffield G, Kho K, Warren AJ (2002) Signs and symptoms of psychotic illness (SSPI): a rating scale. Br J Psychiatry, 180:45-50.

Luborsky L, Crits-Christoph P, Mintz J, Auerbach A (1988) Who Will Benefit from Psychotherapy? Predicting Therapeutic Outcomes. Pennsylvania, Basic Books.

Markova IS, Berrios GE (1992) The meaning of insight in clinical psychiatry. Br J Psychiatry, 160:850-860.

Marková I (2005) Insight in Psychiatry. Cambridge, Cambridge University Press.

Marková IS, Roberts KH, Gallagher C, Boos H, McKenna PJ, Berrios GE (2003) Assessment of insight in psychosis: a re-standardization of a new scale. Psychiatry Res, 119:81-88.

Marks KA, Fastenau PS, Lysaker PH, Bond GR (2000) Self-appraisal of illness questionnaire (SAIQ): relationship to researcher-rated insight and neuropsychological function in schizophrenia. Schizophr Res, 45:203-211.

McEvoy JP, Freter S, Everett G, Geller JL, Appelbaum P, Apperson LJ et al. (1989) Insight and the clinical outcome of schizopheric patients. J Nerv Ment Dis, 177:48–51.

Medalia A, Thysen J (2008) Insight into neurocognitive dysfunction in schizophrenia. Schizophr Bull, 34:1221-1230.

Medalia A, Thysen J, Freilich B (2008) Do people with schizophrenia who have objective cognitive impairment identify cognitive deficits on a self report measure? Schizophr Res, 105:156-164.

Messer SB, McWilliams N (2007) Insight in psychodynamic therapy: theory and assessment. In Insight in Psychotherapy (Eds LG Castonguay, CE Hill):9-29. Washington, American Psychological Association.

Mintz AR, Dobson KS, Romney DM (2003) Insight in schizophrenia: a meta-analysis. Schizophr Res, 61:75–88.

Muz FNO, Metintas S, Onsuz MF, Sungur S, Tepetas M, Akdag Z (2024) Nicotine Use Awareness and Nicotine Insight Scale in addicts: a Turkish validity–reliability study. Addicta, 11:164-169.

Neziroglu F, McKay D, Yaryura-Tobias JA, Stevens KP, Todaro J (1999) The overvalued ideas scale: development, reliability and validity in obsessive-compulsive disorder. Behav Res Ther, 37:881-902.

Olaya B, Marsà F, Ochoa S, Balanzá-Martínez V, Barbeito S, García-Portilla MP et al. (2012) Development of the insight scale for affective disorders (ISAD): modification from the scale to assess unawareness of mental disorder. J Affect Disord, 142:65-71.

Özcan T, Kuru E, Şafak Y, Karadere ME, Yavuz FK, Turkçapar MH (2013) Brown İnançların Değerlendirilmesi Ölçeği: geçerlik ve güvenirlik çalışması. Journal of Cognitive Behavioral Psychotherapies and Research, 2:25-33

Pai HC (2015) The effect of a self-reflection and insight program on the nursing competence of nursing students: a longitudinal study. J Prof Nurs, 31:424-431.

Peill JM, Trinci KE, Kettner H, Mertens LJ, Roseman L, Timmermann C et al. (2022). "Validation of the psychological insight scale: a new scale to assess psychological insight following a psychedelic experience. J Psychopharmacol, 36:31-45.

Phillips KA, Hollander E, Rasmussen SA, Aronowitz BR, DeCaria C, Goodman WK (1997) A severity rating scale for body dysmorphic disorder: development, reliability, and validity of a modified version of the Yale-Brown obsessive compulsive scale. Psychopharmacol Bull, 33:17-22.

Piper WE, Joyce SC, Azim HFA (1994) Psychological mindedness, work, and outcome in day treatment. Int J Group Psychother, 44:291-311.

Radford J (1974) Reflections on introspection. Am Psychol, 29:245-250.

Roberts C, Stark P (2008) Readiness for self-directed change in professional behaviours: factorial validation of the self-reflection and insight scale. Med Educ, 42:1054-1063.

Rosen JC, Reiter J (1996) Development of the body dysmorphic disorder examination. Behav Res Ther, 34:755-766.

Sakarya AY (2012) Remisyonda şizofreni ve bipolar bozukluk hastalarında zihin kuramı bozukluklarının içgörü ve diğer bilişsel işlevlerle ilişkisi (Uzmanlık tezi). Ankara, Ankara Üniversitesi.

Sturman ED, Sproule BA (2003) Toward the development of a mood disorders insight scale: modification of Birchwood's psychosis insight scale. J Affect Disord, 77:21-30.

Sutton A (2016) Measuring the effects of self-awareness: construction of the self-awareness outcomes questionnaire. Eur J Psychol, 12:645-658.

Tek C, Uluğ B, Rezaki BG, Tanriverdi N, Mercan S, Demir B et al. (1995) Yale-Brown obsessive compulsive scale and US national institute of mental health global obsessive compulsive scale in Turkish: reliability and balidity. Acta Psychiatr Scand, 91:410-413.

Tüzer V (1996). Markova-Berrios İçgörü Ölçeğinin geçerlilik ve güvenilirliği. Ankara, Ankara Numune Hastanesi.

Vargas MJ (1954) Changes in self-awareness during client-centered therapy. In Psychotherapy and Personality Change (Eds CR Rogers, RF Dymond):145-166, Chicago, University of Chicago Press.

Walvoort SJW, van der Heijden PT, Kessels RPC, Egger JIM (2016) Measuring illness insight in patients with alcohol-related cognitive dysfunction using the Q8 questionnaire: a validation study. Neuropsychiatr Dis Treat, 12:1609-1615.

Weiler MA, Fleisher MH, McArthur-Campbell D (2000) Insight and symptom change in schizophrenia and other disorders. Schizophr Res, 45:29-36.

Wiffen BDR, Rabinowitz J, Lex A, David AS (2010) Correlates, change and 'state or trait' properties of insight in schizophrenia. Schizophr Res, 122:94-103.

Wong SSL, Lee S, Wat KHY (1999) A preliminary communication of an insight scale in the assessment of lithium non-adherence among Chinese patients in Hong Kong. J Affect Disord, 55:241-244.

Yücesoy T, Şeker ED, Karakaş M, Ertürk Zararsız G, Şahbaz ÇD (2022) The validation and reliability study of Turkish versions of Yale-Brown obsessive compulsive scale modified for body dysmorphic disorder and body image disturbance questionnaire. Bezmialem Science, 10:274-280.

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