The Role of Self–Complexity in Reducing Harmful Insight Among Persons with Schizophrenia. Theoretical and Therapeutic Implications

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Persons with schizophrenia who have insight of their disorders might experience depression, hopelessness, and related suicidality. Although the concept of self–complexity appears to be highly relevant as a self–regulating mechanism in the process of coping with depression and hopelessness in populations without schizophrenia, it hardly plays a role in current discussions of the determinants of harmful insight in schizophrenia. In this article the correlates of the harmful impact of insight among persons with schizophrenia and the possible buffering role of self–complexity against harmful influences of insight are discussed.

KEYWORDS: self-complexity, schizophrenia, harmful insight, depression

INTRODUCTION

There is a wide–ranging consensus that suggests many suffering from schizophrenia experience themselves as diminished relative to their former selves, i.e., after onset they experience themselves as less able to engage the world effectively, which intensifies their anxieties in the face of everyday interactions (Lysaker & Lysaker, 2008). Insight into or awareness of illness carries risk, as does the lack of insight (Lewis, 2004). Relative to persons with other psychiatric disorders, persons with schizophrenia spectrum disorders are often unaware (or willfully contest) that they have what others think to be a mental illness. Taken as a whole, this phenomenon, often referred to as "lack of awareness" or "poor insight," has shown a pattern of apparently contradictory associations with outcome (Lysaker et

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al., Lysaker, Roe, & Yanos, 2007). Poor insight (I will refer to "awareness of illness" throughout the article when it is not otherwise defined) has been linked to poorer treatment adherence, poorer clinical outcome, poorer social function, vocational dysfunction, and difficulties developing working relationships with mental health professionals (Lysaker et al., Lysaker, Roe, & Yanos, 2007). On the other hand, greater insight has been associated with higher levels of dysphoria, lowered self–esteem, and decreased well–being and quality of life (Lysaker et al., Lysaker, Roe, & Yanos, 2007). Although the neurobiology of general and specific insight has not been determined, data from neurocognitive and a few structural imaging studies provide some understanding of the neurobiological underpinnings of insight dysfunction in schizophrenia (Shad et al., 2007), which might have serious consequences for coping and adjustment abilities of the patient. While interest has grown steadily in understanding how persons with schizophrenia appraise their disorder and subsequent needs, the nature of the impact of awareness or admission of disorder on various domains of quality of life has remained a matter of considerable debate (Lysaker & Louria, 2007).

In this article the harmful effects of insight in persons with schizophrenia are discussed and the role of self–complexity as buffering force against harmful consequences of insight will be examined.

CONCEPTUAL BACKGROUND OF INSIGHT IN SCHIZOPHRENIA

The Oxford Dictionary of English (2007) defines insight (general or specific) as the capacity to understand hidden truths, especially of character and situation. But, the concept of insight in the psychiatric context evokes different meanings (Saravanan et al., 2004). In 1911, Karl Jaspers was the first psychiatrist to note that many psychiatric patients are unaware of being ill (Jaspers, 1963/1913; It was first published as Algemeine Psychopathologie by Springer Verlag, 1913]). Aubrey Lewis expanded on this concept in 1934 with an article in which he settled poor insight as being the inability to recognize a morbid process within oneself (Lewis, 1934). Then this definition of insight went underground, and the Freudian concept of denial largely replaced it. Denial, as a psychological defense mechanism, is a much broader concept than a Jasperian lack of insight. Denial applies to the inability to recognize unconscious emotions that lead to conscious mental states. In the era of psychoanalytic dominance, insight meant a specific kind of understanding, usually related to distovering symptoms as connected to unconscious emotions (Henry & Gheami, 2004).

Insight in psychosis is a complex and controversial phenomenon (Saravanan et al., 2004) and has a paradoxical place in late 20th century psychiatry (Fulford, 2004). As the central feature of key psychotic symptoms such as delusion and hallucination, loss of insight has proven peculiarly difficult to define, so much so that determined attempts have been made to eliminate the traditional psychotic/nonpsychotic distinction from psychiatry (Fulford, 2004). Insight and its derivative insightlessness, including loss of awareness of illness or incapacity to gain it in the first place, are concepts sitting at the incomplete convergence between word, concept, and behaviour. Equally important to the development of a concept of general and specific insight have been the psychological notions of consciousness, introspection, and self. Additionally, it is difficult to map out the semantic structure of insight because of the uncertain origins of the concept (Berrios & Mrakova, 2004).

Lack of insight is often seen as a defence against the potentially devastating realisation of a person's illness. Lack of insight may be viewed as misattribution, a form of cognitive error based on lack of information, systematic biases, or idiosyncratic beliefs. Misattribution rests on the assumption that there is a correct attribution for symptoms and experiences with respect to some goal. Individuals' perspectives, beliefs and values should be taken into consideration when we assess something as complex as general and specific insight. (Saravanan et al., 2004). A criticism of the traditional concept of general and specific insight is that it fails to take into account cultural idioms and is Eurocentric (Saravanan et al., 2004). The author agrees with Saravanan et al. that general and specific insight is culturally determined. Furthermore, the author suggests that the development of general and specific insight, like all our social–emotional, cognitive functioning, might be the product of ethnic, religious, intrapsychic, psychosocial, neurobiological and even genetic influences (see Martens, 2007). The author emphasizes further the complex role of insight in the disorder is not a static condition, but is related to an enduring learning process, reality testing, self–investigation, self–evaluation and self–confrontation (because illness will interact with distinctive aspects of self such as interpsychic forces and social–emotional and cognitive characteristic and personality traits), evaluation of interactions with the outside world in comparison of self to others, and an attempt to understand the relationship between self and the outside world, and discovery of the hidden layers of desires, drives, internal conflicts and frustrations.

Insight is operationally defined by Mintz et al. (2003) according to five dimensions, which include the patient's awareness of mental disorder,

awareness of the social consequences of disorder, awareness of the need for treatment, awareness of symptoms and attribution of symptoms to disorder.

DANGERS OF INCREASING INSIGHT IN PATIENTS WITH SCHIZOPHRENIA

Introduction

May (1984) concluded after analysis of 40 controlled studies that too much (and too swift) uncovering and self–disclosure is harmful for some persons with schizophrenia. Insight, or awareness of illness, has been considered a risk factor for suicide in patients with schizophrenia (Pompili et al., 2004; Schwartz & Smith, 2004). Schwartz (1999a) revealed in a large–scale study of patients with schizophrenia that as insight into the need for treatment increased, reports of suicidality also increased. A later replication of this research design provided additional evidence that greater awareness of illness may, in fact, predispose psychotic patients to a demoralization syndrome, which might culminate in suicidality (Schwartz & Petersen, 2000; Schwartz & Smith, 2004). Schwartz (2000) investigated the correlation between insight and degree of suicidality among adult patients (n = 267; aged 18 years to 71 years) with schizophrenia using the Scale to Assess Unawareness of Mental Disorder and the Structured Clinical Interview for the Functional Assessment Rating Scale ([FARS]; Ward et al., 1995), an instrument designed to assess severity of symptomatology of mental disorders. Results are consistent with the general findings of the earlier study; that is, there was a statistical correlation between increased insight and more severe suicidality among patients with schizophrenia (Schwartz, 2000). However, using the Scale to Assess Unawareness of Mental Disorder and an instrument that measured multiple aspects of psychopathology in a sample of persons with schizophrenia (n = 218), Amador et al. (1996) revealed that general awareness of having a mental disorder did not predict suicidal behavior. Patients with schizophrenia with recurrent suicidal thoughts and behaviors were generally more aware of their negative symptoms and delusions than were nonsuicidal patients. The notion that insight may be associated with greater suicidality was, however, partially supported (Amador et al., 1996). Thus the link between increased insight and increased risk of suicide might be rather complicated because this association will be mediated by other risk factors, which will be discussed later. In many patients with schizophrenia, suicide appears as a result of a longer–lasting development, characterized by a deleterious illness course and marked decline in psy-

chosocial functioning; in insightful patients, suicidality occurs upon realizing that they are unable to keep pace with their peers or unable to live up to their own expectations (Modestin, 2007).

Correlates of Harmful Impact of Insight

The following correlates of the harmful impact of insight among persons with schizophrenia are reported in distinctive empirical and theoretical studies:

1) Too much (and too swift) uncovering and self–disclosure, might lead to breakdown of the defense mechanism that otherwise protects the ego of the patients with schizophrenia (Kanas, 1985). This breakdown of the defense mechanism might result in psychosis, depression, and anxiety, whereas agitation and aggressiveness might function as the ultimate defense against progressive and complete breakdown.
2) Risk for the development of depression (Crumlish et al., 2005; Lester, 2007; Lewis, 2004; Modestin, 2007; Wilson & Amador, 2007; Wittmann & Keshavan, 2007), hopelessness (Lester, 2007; Modestin, 2007; Wilson & Amador, 2007), and associated likelihood to attempt suicide (Crumlish et al., 2005; Lester, 2007; Modestin, 2007; Wilson & Amador, 2007) increase when some patients become aware of their diagnosis. Crumlish et al. (2005) assessed 101 individuals with first–episode schizophrenia and schizophreniform disorder at presentation, 6 months and 4 years, and they measured insight, including recognition of mental illness, recognition of need for treatment, and ability to relabel psychotic symptoms. They measured depression and recorded all suicide attempts. It appears that insight improved with time. Recognition of mental illness at 6 months predicted depression and attempted suicide at 4 years. Six months after presentation, the greater the acknowledgement by individuals that they had a mental illness, the more depressed they were at 4 years and the greater the likelihood that they would attempt suicide by 4 years (Crumlish et al., 2005).

Research to date suggests that awareness of illness is associated with increased suicide risk, but only if that awareness leads to increases in hopelessness (Wilson & Amador, 2007). Lester (2007) revealed also that hopelessness appears the stronger predictor for future suicidality in many of the studies (Lester, 2007). Kim et al. (2003) revealed also in their prospective study of a sample of patients with chronic schizophrenia (n = 333; mean age 35.2 years) that greater insight was asso-

ciated with both hopelessness and substance abuse. Greater insight was associated with attempted suicide and suicidal ideation. The severity of the hopelessness that a person with schizophrenia experiences seems contingent, at least in part, on their level of premorbid functioning and the magnitude of their decline in functionality relative to that premorbid capacity (Wilson & Amador, 2007). Hopeleseness in persons with schizophrenia appears to result from an awareness of their disorder and their poor prospects for a happy and productive life, and it is reduced when the patients have less insight into their condition (Lester, 2007). The patients who are aware of their illness and of all its psychosocial consequences can lose hope for a better future and faith in therapeutic progress and react with noncompliance, again a factor increasing the danger of suicide (Lewis, 2004; Modestin, 2007 Wittmann & Keshavan, 2007). One other possible explanation for the correlation between awareness of illness and lesser hope and related low self–esteem is that acceptance of having schizophrenia may impact outcomes differently depending on the meanings the person attaches to this acceptance, particularly whether he or she accepts stigmatizing beliefs about mental illness (Lysaker et al., Lysaker, Roe, & Yanos, 2007). "Awareness of illness" has been suggested to represent the acceptance of a system of social power in which one's individuality and dignity is at risk for being diminished (Lysaker & Louria, 2007) and the interal acceptance of stigmatization. To explore this possibility, Lysaker, Buck, and Hammoud (2007) performed a cluster analysis of 75 persons with schizophrenia–spectrum disorders based on single measures of insight using the Positive and Negative Syndrome Scale and internalized stigma using the Internalized Stigma of Mental Illness Scale. They compared groups on concurrent assessments of hope and self–esteem. Three groups were produced by the cluster analyses: low insight/mild stigma (n = 23), high insight/minimal stigma (n = 25), and high insight/moderate stigma (n = 27). As predicted, analysis of variance–comparing groups revealed that the high insight/moderate stigma group had significantly the lowest levels of hope on the Beck Hopelessness Scale and self–esteem using the Multidimensional Self–esteem Inventory. As predicted, the high insight/minimal stigma group also had significantly less impaired social function than the other groups (Lysaker et al., Lysaker, Roe, & Yanos, 2007).

The author speculates that the link between the awareness of illness and hopelessness might be constituted by an interplay between the impact of foreseeing the consequences of critical internal conditions (emotional/

cognitive instability and dysfunctions, inadequate coping skills, inability to read other people's mind, resistance/incapacity to change, anxiety and fear of living, lack of locus of control, shame, feelings of inferiority, and depression) and aversive external influences (stigmatization, lack of social support, lack of understanding of other people and related lack of positive feedback, lack of social integration possibilities, and social isolation), which interact and reinforce each other. Long–lasting suffering from negative internal and external consequences might easily result in learned helplessness (see Seligman, 1975, 1998), which is characterized by the increasing convincement of a person that he/she is unable to have significant impact on and control over life. Learned helplessness might thus form a stable basis of hopelessness. As a consequence of this development, the patient will demonstrate a severe lack of initiative to change and improve his/her life circumstances. Moreover, there is increased risk that apathy and helplessness grows so strong that it results in weariness and lack of motivation to stay alive, which might in turn lead to a) refusal to eat, drink, or initiate other life supporting activities, and b) active suicide attempts.

Furthermore, feelings of loss and inferiority about the illness might be linked to depression and might be experienced as a damaging life event. Feelings of mourning for losses might be engendered by the awareness of illness. However, grief and mourning are also a necessary part of coming to terms with having the illness. Recovery depends on mourning illness–related losses, developing personal meaning for the illness, and moving forward with "usable insight" and new identity (Lewis, 2004; Wittmann & Keshavan, 2007)

3) Awareness of their asociality (agitation, impulsivity, aggressiveness) (Amador et al., 1996; Modestin, 2007), blunted affect (Amador et al., 1996), and anxiety (Modestin, 2007) correlate with more extreme suicidality (Amador et al., 1996), especially if these symptoms are accompanied by an illness insight (Modestin, 2007). The author speculates that awareness of limitations that are paired with schizophrenia in combination with the extra limitations and negative consequences of traits considered comorbid (criteria for other mental disorders), such as uncontrollable agitation, aggressiveness, impulsiveness, all antisocial traits, and anxiety, might lead to increased hopelessness and depression because of the enhanced complication of problems, incapacities, and extra burdens for the patient and his/her environment, and increased severe limitations.

SELF–COMPLEXITY AS BUFFER AGAINST HARMFUL IMPACT OF INSIGHT IN SCHIZOPHRENIA

Linville (1982, 1985) defined self–complexity as the number of self–aspects ([i.e., "sub–selves"] Morgan & Janoff–Bulman, 1994) a person has and the amount of independence among those self–aspects. Compared to people low in self–complexity, people high in self–complexity possess a greater number of self–aspects and greater distinctions among these aspects (Linville, 1985, 1987). Such self–aspects may include information about specific events and behavior, generalizations developed from repeated observations of one's own behavior, or other self–relevant knowledge such as traits, roles, physical features, category membership, abilities, preferences, autobiographical recollections, and relations with others (Koch & Sheppard, 2004; Linville, 1985). Self–concepts refer to one's self–beliefs and self–evaluations and the ability to know how one answers the questions "Who am I?" and "How do I feel about myself?" Increased self–complexity (and more differentiated and integrated selfs–concepts) will function as depression– and stress–buffering internal force (Linville, 1987).

Although the buffering effects of self–complexity against depression and hopelessness have not been examined until now in patients with schizophrenia, it is speculated that self–complexity might also play a significant role in coping with harmful impact of insight in persons with schizophrenia.

Coping with Depression

An increased differentation and integration of self–aspects protects the self from depression(Constantino et al., 2006; Koch & Shepperd, 2004; Woodfolk et al., 2004; Yoshida & Nakamuram, 2007) and this may help patients with schizophrenia to cope with depression. In a sample of university and vocational students (n = 95) who performed a self-description task to reveal self-complexity through structural equation modelling, Yoshida & Nakamuram (2007) found that 1) negative self-complexity indirectly facilitated depression through negative automatic thoughts and 2) positive self-complexity indirectly reduced depression through positive automatic thoughts. The students also completed a questionnaire about positive and negative automatic thoughts and depression.These findings suggest that self–appraisals play a mediating role in facilitating and reducing depression (Yoshida & Nakamuram, 2007). The author revealed that self–appraisals are related to self–esteem (see Martens, 2005a), and as a consequence, self–esteem might also be significant in reducing depression.

Increased Self–Knowledge and Self–Esteem

Structural features of the self may serve as important moderators of the impact of self–knowledge on self–esteem (Showers & Zeigler–Hill, 2006). These structural features include self–schemas, category structures (including self–complexity, differential importance, and compartmentalization), and features of self–definition (including self–concept clarity and contingencies of self–worth). Early cognitive models suggested a one–to–one correspondence between the content of self–beliefs and self–esteem (cf. Rosenberg, 1965). In this view, the more positive one's beliefs about the self, the higher one's self–esteem; conversely, people with low self–esteem should have a greater proportion of negative self–beliefs. In other words, the links between self–esteem and self–knowledge were direct (Showers & Zeigler–Hill, 2006). In fact, Showers & Zeigler–Hill (2006) indicated that positive self–beliefs/self–knowledge is linked to increased self–esteem and this combination forms a buffer against depression, hopelessness, and associated suicide ideation and attempts. The author suggests that increased insight in schizophrenia might be harmless and constructive when it is paired with positive self–knowledge.

Increase of Well–Being and Adjustment

Two studies examine the relations of self–complexity (see Linville, 1987) and the authenticity of self–aspects to well being. Study 1 results show that self–complexity is largely unrelated to well being, whereas the authenticity (being true and real) of the self–aspects that constitute it is associated with greater well being. Study 2 uses a two–week, prospective design to replicate Linville's finding of a buffering effect of complexity on the negative outcomes associated with stressful events. In addition, study 2 results revealed either null or negative relations of complexity to well being, whereas the authenticity of self–aspects was again positively related to well being (Ryan et al., 2005). The author speculates that an authentic self (see Martens, 2005b, 2007) is characterized by self–realization, autonomy, character strength, creativity and independent attitude/opinions, and ability to use (internal) dialogue in order to learn about oneself and defining oneself as a individual. These characteristics could be protecting elements against harmful etiological development because of their constructive, positive and prosocial impact and optimal utilization of their own unique intrapsychic, social–emotional and cognitive capacities.

Dimaggio et al. (2008) concluded, after analyzing relevant studies, that increases of two important correlates of self–complexity, namely self–reflection and mindreading (grasp of other's thoughts and emotions), are

linked to well–being. Only by means of self–reflection/awareness and adequate interplay with the external world, obervation, and understanding of others' internal world, can self–complexity grow. One possible interpretation of the link between self–reflection and mind reading, on one hand, and well-being, on the other, is that human beings need the ability to recognize emotions in themselves to be able to recognize emotions in the expressions and voices of others. When this ability is compromised in schizophrenia, individuals may lose the ability to detect emotions in others and manifest negative symptoms (Dimaggio et al., 2008; Lysaker, Dimaggio, Buck, Carcione, & Nicolo, 2007). Consequently, satisfying such a basic need is required for the realization and maintainence of well being.

Increase of Adjustment

Campell et al. (2003) analysed the results of four studies that examined the relations among measures of self–concept structure and their relations with adjustment. The measures of self–concept unity, in which the attributes and characteristics are correlated with each other, were moderately related to one another and were moderately related to the measures of adjustment (Campbell et al., 2003). However, there was not a correlation of adjustment with self–pluralism (the variety of attributes and characteristics). The author suggests that self–concept unity, because of the strong cohension between the various self–concepts, resulting absence of significant conflicts, and associated greater motivation for adjustment, tactical insight, and will–power, leads to an easier and adequate adjustment.

The author speculates that persons with schizophrenia who suffer from the harmful consequences of insight might demonstrate insufficient self–complexity (less differentiated and less integrated self–concepts) compared with persons without schizophrenia or patients with schizophrenia who do not suffer from harmful effects of insight. Enhanced self–complexity appears to reduce, and even block, the development of depression, hopelessness, low self–esteem, and might indirectly influence (diminish) suicidal tendencies. The author suggests that self–complexity may function as a means coping with harmful aspects of insight through the availability of variations of social–emotional and cognitive perspectives (learned in different roles and attitudes) and an associated increase in mental and social–emotional flexibility. Flexibility is characterized by a capability to adjust and correct inadequate, incomplete, and/or wrong perspectives and thinking. If necessary, it might facilitate completion of views or thoughts with other relevant information and thoughts. Social–emotional and men-

tal flexibility is required for the obtaining and processing of adequate insight. Adequate insight disclosures provide effective strategies for a) coping with problems in addition to those related to their disease and b) (re)discovering real life and nature, which is necessary for adequate responses to the demands and influences of the outside world. Well–differentiated and integrated and authentic self–concepts are required for optimal intrapsychic, psychosocial, social–emotional, and cognitive self–regulation, which forms an effective and constructive defense against a) bad influences, such as stigmatization because of disease, b) misattributions and wrong assessments by the patient concerning his/her internal capacities and possibilities and outside world (situations and intentions of other persons), and c) the impact of negative experiences, attacks on self–esteem, and the related development of negative self–appraisal. Optimal self–complexity and development of sophisticated, authentic and well–organized self–concepts are also the result of self–investigation, self–knowledge, and positive interaction with and feedback from the outside world. Adequate self–complexity can only be developed effectively in healthy cooperation and interaction with the outside world.

HOW MIGHT PSYCHOTHERAPY FOSTER INCREASE OF SELF–COMPLEXITY

The author suggests that the narrative be might effective in growth of self–complexity, because it might increase a) self–investigation and self–awareness, b) exploration of the external world, and c) the capacity to internal and external dialogue. The enhanced capacity for external/internal dialogue and increased self–investigation and self–awareness might lead to discovery of unknown parts of self or subselves (also provoked by stimuli from the outside world) and to growth of self–complexity. France & Uhlin (2006) revealed that narrative is an outcome domain for psychosis, which frames the personal construction of meaning as a key ingredient in recovery. In particular, psychotherapy can assist persons with schizophrenia to develop a narrative that allows for recovery by creating a context for increasing self–awareness and related self–complexity and agency (Lysaker, 2001). Lysaker, Buck, and Hammoud (2007) emphasized that part of recovery involves persons reclaiming a sense of their own identity, agency, and personal worth. Integrative psychotherapy might address issues of self–narrative and recovery from schizophrenia among persons experiencing, in particular profound levels of emptiness or barrenness. Lysaker, Buck, and Hammoud (2007) describe integrative interventions that may revitalize dialogues within the client and between the client and

others. Ultimately, these may enable the reconstruction of a client's personal narrative within which a life plan might be articulated, guiding future action. Furthermore, persons recovering from schizophrenia often do not see themselves as possessing agency, social worth, or an integrated sense of themselves and their experiences. Integrative psychotherapy (for details see Lysaker, Buck, & Roe, 2007b), which involves helping clients construct narratives of their experiences in the context of collaborative nonhierarchical relationships (and which might also be linked to an integrated sense of self and increased self–complexity), may prove helpful (Lysaker, Buck, and Roe 2007). The author suggests that the integrative psychotherapy might be effective in combination with psychosocial guidance of the patient and family, psycho–education, medication, and social integration.

DISCUSSION

For those patients who are largely (or partly) unaware of their disease, obtaining insight might be experienced as an awakening in a foreign, demanding, and perhaps, dangerous reality. The state of being created by increased awareness might be completely different from the former condition of lack of awareness. Even if the awareness is linked only to one crucial fact, such as loneliness as a consequence of disorder or stigmatization, this might cause a dramatic change in the life of the patient. The illusion of safety or interactions that are linked to hallucinations or delusions will be disturbed by the progression of insight and associated reality testing. Furthermore, increaseed insight in persons with schizophrenia (as well as in most people) might be linked to a general increase of distress or sorrow because it will automatically throw light onto the dark and unbearable sides of internal and external life. Ancient wisdom already predicted "For in much wisdom is much grief, and increase of knowledge is increase of sorrow" (Ecclesiastes 1:18; New American Standard Bible, 2005). Insight into the deeper layers of self and life might result in discoveries of unpleasant and even unbearable facts. I discovered, in a sample of completely remitted psychopathic patients (psychopathy is characterized by an absence of depression or distress), that an increase of intense and emotional/empathic dimension of insight brought about serious depression, sorrow and distress because these patients became aware of (and regret) their former destructive characters/lifestyles and related negative consequences (Martens, 1997). Increased levels of insight into their disorder in this population was linked to a) increased self–investigation and reality testing, b) spiritual and philosophical interests, c) discovery

of unknown social–emotional and moral areas, d) a revealing of former denied sides of self (severe limitations and incapacities, negative and devastating character traits). The author suggests that an increase of insight/awareness might have an impact on other social–emotional and cognitive areas. For example, insight into their mental disorders will easily lead to insight in their social–emotional interactional problems, the causes of their loneliness, and lack of necessary experience in dealing with life and social–emotional problems.

It is further speculated that a healthy development of self–complexity is interfered with by a variety of adverse etiological factors and consequences of the disorder, such as social isolation and a lack of social–emotional interaction capacities (and possibilities that might facilitate development of such capacities). Adequate development of self–complexity is thus only possible during learning moments characterized by effective interaction with the outside world. Increase of insight might not only lead to an increase of risks of harmful effects of insight but also might lead to further development of self–complexity. Furthermore, the author agrees with Lewis (2004) and Wittmann & Keshavan (2007) that negative consequences of insight after a long period of unawareness might affect persons without schizophrenia similarly, with depressive aftereffects. It may be a sometimes necessary (and temporary) evil required for the process of growth, improvement, and even recovery.

CONCLUSION

Self–complexity appears to have a significant buffering effect against the harmful effects of insight, such as depression and hopelessness in persons without mental disorders. It is hypothetized further that self-complexity might have the same positive buffering effects in patients with schizophrenia. Studies into to buffering effects of self–complexity in persons with schizophrenia are warranted.

Desirable increases of self–complexity will be linked to increases of social–emotional and cognitive awareness/capacities because these are required for an increase of self–aspects, which may include information about specific events and behavior, generalizations developed from repeated observations of one's own behavior, or other self–relevant knowledge, such as traits, roles, physical features, category membership, abilities, preferences, autobiographical recollections, and relations with others (see Koch & Sheppard, 2004; Linville, 1985). Therefore, simultaneously training for self–complexity and social–emotional and cognitive abilities in

specially designed therapeutic programs could be effective in preparing and guiding patients with schizophrenia through the process of developing insight.

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