



Why using “consciousness” in psychotherapy? Insight, metacognition and self-consciousness

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ARTICLE INFO

Keywords:

Consciousness
Insight
Metacognition
Self-consciousness
Clinical psychology
Psychotherapy

ABSTRACT

Since its early development, clinical psychology has questioned the impact of “consciousness” on the determination of human responsibility across psychiatric disorders. In recent years, specific clinical approaches have focused on “consciousness” work that could play a key role in psychotherapy. We focused our research on clinical psychology’s consciousness-related concepts of insight, self-consciousness, and metacognition. Insight and metacognition, for example, have prompted increased interest in schizophrenia (SZ), bipolar disorder (BD), and, more recently, borderline personality disorder (BPD) treatments as representative of the latest advances in the cognitive and behavioral therapy field. Here we review cognitive, social, and clinical psychology research measuring “consciousness” in BPD, SZ, and BD, exploring the implications of different conceptualizations of consciousness-like concepts for treatment adherence, symptom evolution, and related aspects of psychotherapy. Our results show the overall relevance of using measures of clinical and cognitive insight, emphasizing the more central role of cognitive insight and metacognition in psychotherapy, as it appears that consciousness can remain useful if understood as a cognitive skill. The inclusion of a conceptualization of self-consciousness is important in order to address the social component of psychotherapy, as it does in biopsychosocial approaches. We discuss the implications of such results for global efficacy, for the relevance of the “consciousness” concept to clinical psychology, and for the potential need to keep operationalizing different conceptualizations of it in psychotherapy. We open the debate on the definition of consciousness to motivational aspects of change and to general considerations of both legal and ethical aspects.

1. Introduction

As clinical psychologists, we learn about “consciousness” from the very beginning of our education in psychology, and the “deranged” ones are assumed to be those who do not know what they are doing. Many common understandings in certain countries are still biased toward earlier theories of human psychology such as psychoanalysis, so our patients are “trained” with us to refer to psychoanalytical wording and theories. Issues of “consciousness” in connection with mentally ill persons’ responsibility have existed since the beginning of psychopathology, and it has been regarded as a curative mechanism to leverage since the emergence of the theory of “consciousness” from Freud’s vision of psychoanalysis. More recently, “consciousness” terminology has appeared in psychodynamics and in cognitive behavioral therapy (CBT), marking “consciousness” as a “must have” for patients, a hidden gem to find inside oneself to properly express emotions and thoughts, and

needed in order to implement change or develop new coping strategies (Caligor et al., 2007; Strachey, 1934).

When asking psychiatric patients about their experience, we often stumble on statements such as “I had no consciousness of that,” uttered to avoid taking responsibility for one’s behavior. Moreover, depending on the particular context and language, we should note that not all languages offer such a variety of words as does English to refer to the different components of consciousness, for example, mindfulness, awareness, and insight, terms that are all used as specific concepts but can be all translated as *conscience* in French. The common word “consciousness” can also refer to the ability to observe, recognize, notice, sense, and understand one’s internal reactions to stimuli, and clinical psychologists need to distinguish which of these conceptions of “consciousness” are relevant to their practice and to treatment adherence. CBT psychotherapy that includes meditation techniques thought to exploit working “consciousness” (note that in French, Spanish, and

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<https://doi.org/10.1016/j.newideapsych.2023.101015>

Received 8 December 2022; Received in revised form 26 February 2023; Accepted 27 February 2023

Available online 29 March 2023

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Portuguese, for example, “mindfulness” is translated as “full consciousness”) puts a greater emphasis on moral or psychoanalytic vocabulary. This can create obstacles for practitioners addressing communities in which this misleading definition can affect the therapeutic alliance or even basic comprehension of CBT exercises. Based on a literature review, we discuss the different issues and clinical implications of using the concept of “consciousness” in psychotherapy.

Recently, Michel et al. (2019) questioned the “consciousness” issue in both the psychology and medical fields: “Achieving a better understanding of consciousness is critical to multiple medical, scientific, legal, and ethical issues” (p. 104). These areas include the study of self-consciousness (i.e., consciousness of oneself) and metacognition (i.e., consciousness of internal cognitive processes). Despite methodological difficulties, attempts to acquire data about subjective experiences have helped move theoretical debates on consciousness toward testable empirical experiences (Lau & Rosenthal, 2011), but its relationship with psychiatric care remains to be specified.

In applied clinical psychology, the use of terms related to consciousness has impacts at two levels: the legal or forensic level, i.e., “Is the patient still in contact with common reality (are they delusional or responsible)?,” and the capability level, i.e., “Is the patient capable of acknowledging certain mechanisms involved in their suffering, and if so, can they be motivated to change?” Indeed, “consciousness” is questioned in the most common psychiatric disorders, such as schizophrenia (SZ) (depersonalization, delirium, hallucinations, and dissociation), bipolar disorder (BD) (manic phase), and personality disorders such as borderline personality disorder (BPD) (quasi-psychotic symptoms). All these disorders appear to be highly prevalent and to represent a real burden for health services (Charlson et al., 2018). For example, there were 20.9 million cases of SZ worldwide in 2016 according to a systematic literature review and meta-analysis search (see systematic literature review and meta-analysis from Charlson et al., 2018); the pooled lifetime prevalence of BD was 1.06% for BD Type 1 (see systematic literature review and meta-analysis search from Clemente et al., 2015); and the prevalence of BPD was 1.7% in the general population but up to 15–28% in the psychiatric population in 13 countries in 2018 according to a systematic literature review and meta-analysis search (Gunderson et al., 2018). A therapy-relevant definition of consciousness could be of use to clinical psychologists, as the above disorders often entail treatment-adherence difficulties related to lack of “consciousness” and then tend to be considered “hard to treat”.

1.1. A cue to treatment

Recent research is questioning the different definitions of consciousness related to insight, awareness, and (self)consciousness found in all fields of psychology. Ouwersloot et al. (2020) recalled the recent trend of psychotherapeutic development focusing on patient consciousness. For example, starting in the 2000s, mentalization-based treatment (Bateman & Fonagy, 2004), mindfulness-based CBT (Kabat-Zinn, 2003a, 2003b; Teasdale et al., 1995), and acceptance and commitment therapy (Hayes, 2004), all using mindfulness skills, began to flourish; these approaches are still expanding today. We relate mindfulness techniques to consciousness-related mindfulness-based interventions in which the patient is instructed to pay attention to the present moment and act non-judgmentally using mental practices to focus attention on the body (self-consciousness), observe thoughts (metacognition), and cultivate awareness (insight) (Bulzacka, Lavault, Pelissolo, & Bagnis Isnard, 2018). Indeed, to implement change, one needs awareness of the dysfunctions one is experiencing, so, at the basic level of psychotherapy, we aim to reconstruct the psychological architecture by activating emotion in the here and now, and changing consciousness (Derksen, 2012). For example, insight was related to psychotherapy outcomes in a 2018 meta-analysis in which the correlation was moderate ($r = 0.31$) (Jennissen et al., 2018), even though the authors noted that the insight–outcome relationship was rare. Moreover,

the relationship between the insight measure and suicide risk has been proven to be weak (Vilaplana et al., 2015), calling into question the actual impact of consciousness—or insight-based—therapy.

The most recent development of CBT has emphasized more precise protocols focusing on insight and metacognitive processes (Moritz et al., 2019) based on the third wave of CBT development (i.e., MBCT and ACT) (Hayes, 2004; Kabat-Zinn, 2003a, 2003b; Teasdale et al., 1995). However, it can be complicated to clarify the implications of consciousness skills in terms of different conceptual frames, psychological theories, and applications. We will accordingly explore the distinct aspects of “consciousness” encountered across clinical psychology from different fields of psychology as used in three major psychiatric disorders, i.e., BPD, BD, and SZ. Reviewing the literature shows that all these aspects have been scrutinized in terms of metacognitive, insight, and self-consciousness issues in all three disorders.

2. Methods

As clinical psychologists, we base our method on multiple aspects of psychological consciousness (and their validated assessment scales) ranging from cognitive to clinical and social perspectives. In the literature, we find corresponding measures used for the three disorders connected to different consciousness-related measures (see Table 1). Clinical insight (Choudhury et al., 2021; Raffard et al., 2010; Tharyan & Saravanan, 2000), cognitive insight (Simon Exposito & Felipe Castaño, 2018; Van Camp et al., 2017), metacognition (Popolo et al., 2017; Wells & Cartwright-Hatton, 2004), and self-consciousness (Alloy et al., 2009; Senín-Calderón et al., 2017; Smári et al., 1994) have all revealed their usefulness in caring for and understanding psychiatric disorders.

3. Results

3.1. Consciousness issues from axis 1 disorders to axis 2 disorders

Consciousness in Axis 1 disorders such as BD and SZ has been widely explored. Regarding Axis 2 disorders (i.e., personality disorders, including BPD), some approaches suggest that consciousness issues also merit being addressed, with the most represented concept being insight (David, 2020; Hasson-Ohayon, 2018).

Various measures of insight are available, but they are often disorder

Table 1
Example definitions across reference articles.

Consciousness-related vocabulary	Example definitions
Insight (Clinical)	“In psychiatry, insight with respect to an illness broadly refers to the ability of the patient to be consciously aware of the illness, recognize that their symptoms are indicative of mental illness and that these symptoms require treatment” (Choudhury et al., 2021, p. 378).
(Cognitive) Insight	“The concept of cognitive insight refers to the capacity for self-reflectiveness as a mechanism for evaluating one’s symptoms and self-certainty, understood as the ability to correct inappropriate interpretations and conclusions” (Simon Exposito & Felipe Castaño, 2018, p. 251).
Metacognition	“As research on metacognition has expanded, the construct has come to encompass a spectrum of activities which range from noticing discrete thoughts, wishes and feelings, being aware of attentional biases and ultimately integrating these phenomena into a more complex sense of oneself and others which is needed to negotiate psychosocial challenges” (Popolo, 2017, p. 45).
Self-consciousness	“Self-consciousness may be defined as the ability of being the subject of one’s own attention to internal processes (private self-consciousness) or to oneself in public (public self-consciousness)” (Senín-Calderón et al., 2017, p. 446).

specific and cannot always be generalized to other disorders. For example, the ISAD scale for BD (Olaya et al., 2012) was adapted in 2012, creating the Scale to Assess Unawareness of Mental Disorder (SUMD), which is the reference clinical insight measure but was first designed to assess insight in SZ patients (Dumas et al., 2013). Among the most used measures are the Beck Cognitive Insight Scale (Bulzacka, Lavault, Pelissolo, & Bagnis Isnard, 2018) insight scale (Büchmann et al., 2019), and variations of these. A recent publication using different scales in SZ explored the difficulty of accurately assessing insight, even in a well-known disorder, but raised hopes of the more multidimensional consideration of insight including its cognitive and clinical aspects (Capdevielle et al., 2021). A study of BD recalled the diversity of scales but noted that they are all consistent, confirming the poor insight level during mania and its increased level during depressive phases (Choudhury et al., 2021). Depending on the disorder, the measured consciousness can vary and may not be considered fixed.

We first clarify what insight can be in its different forms and its potential link to therapeutic work.

3.2. Insight

Psychodynamic theory stresses that insight is broader than consciousness as it also involves cognitive and affective components. The first understanding was that the self-understanding resulting from insight would result in fewer negative reactions, better adaptation skills, more positive emotional experiences, and greater freedom to choose adaptive interpersonal and health-related behaviors (Lemma, Target, & Fonagy, 2011). However, later research questioned the positive effects of increased insight, as it could also lead to adverse effects, such as depression, in which heightened insight often means worsening depressive symptoms (Belvederi Murri et al., 2016), or even increased suicide rates (Massons et al., 2017). The question is how to properly define “insight” in the field of psychiatric care (Messer & McWilliams, 2007) and how it stands as a prerequisite for treatment: one must be conscious of change, because if one is aware of nothing identified as problematic, one will not bother to change. CBT defines insight as the ability to be oriented toward the self-understanding of one’s own beliefs, emotions, and symptoms (Castonguay & Hill, 2007). A recent meta-analysis recalled that this specific “insight” factor can be considered impactful in psychotherapy (Jennissen et al., 2018). Moreover, apart from being a psychotherapeutic skill, insight is recognized for its implications in improving the quality of life of psychiatric patients, as Sagayadevan et al. (2019) pointed out: “An understanding of cognitive insight is necessary to produce a significant change in the underlying belief system of an individual” (p. 1); however, the same authors then specified that “together with clinical insight, these two forms of insight can be used to inform therapeutic approaches to increase awareness and improve the Quality of Life of those with mental illnesses” (p. 1). The difference between cognitive and clinical insight may still appear relevant.

3.3. Insight and its duality

The concept of insight goes back to the considerations of 19th-century alienists who, in defining legal responsibility, attempted to decide whether patients were aware of themselves and of what they were doing, and whether or not the illness had altered their sense of self. It was then a question of deciding whether this “awareness of the illness” or “insight” was present in a wide variety of disorders, from dementia to schizophrenia, not to mention eating disorders, bipolar disorders, and anxiety disorders, as this had a strong impact on the course of the illness. Insight was linked from the beginning to different prognostic and diagnostic variables in both psychiatric and neurological disorders.

There is an extensive literature on insight, mainly as concerns SZ or BD (for reviews, see Belvederi Murri et al., 2016; Garcia et al., 2016; Leclerc, Noto, Bressan, & Brietzke, 2015; Tham et al., 2016; Velligan

et al., 2017). There was no consensus in the literature on SZ about the relationship between insight and symptomatology. Mintz et al. (2003) reported conflicting studies: some showed an association between insight and all positive and negative symptoms, while others did not prove this link; in their meta-analysis, the authors concluded that symptom severity was involved in the level of insight.

Links between the level of insight and mood disorders also exist (da Silva et al., 2016). Sajatovic et al. (2002) explored factors promoting a lack of adherence in BD treatment, identifying the impact of a lack of insight. Specifically, de Assis da Silva et al. (2015) explored the impact of insight during the distinct phases of BD, finding that patients in the manic phase had poorer insight, poorer adherence, and compliance difficulties. In another study, da Silva et al. (2016) proved the influence of low insight, resulting in severe mood changes. Indeed, low insight was linked to altered thought and speech patterns and increased motor agitation symptoms. In a review, Latalova et al. (2011) noted that, in BD, the impairment of executive functions as well as severity of delusional symptoms were associated with impaired insight. The authors also noted that insight was poorer in the acute phase of the disorder as well as in mixed episodes (vs. pure manic episodes) and that it was more impaired in Type 2 than Type 1 BD (even though delusions are more representative of Type 1 BD).

Insight is gradually being defined in terms of two opposing concepts, with one definition referring to the awareness of mental operations (Despine, 1875; Maudsley, 1895) and the other to all the judgments and awareness that patients bring to bear on the impact of their illness (Billod, 1882; Dagonet, 1881; Parant, 1888). Today, this would refer more to the concept of insight and metacognition, or to the still usual distinction between cognitive insight and clinical insight.

Insight is conceived as a multidimensional concept strongly involved in treatment adherence (Amador et al., 1994; Beck et al., 2011; Sendt et al., 2015). Its “clinical” version has been defined as the ability to admit to one’s illness, to the importance of medication adherence, and to the attribution of correct symptoms (Beck & Warman, 2004; David, 1990). The “cognitive” version has been defined by experts as the ability to critique erroneous beliefs about oneself (Beck & Warman, 2004), which could then be targeted by cognitive remediation skills (Bellani et al., 2019). These two clinical and cognitive forms of insight have been widely evaluated in SZ and BD (for a review, see Van Camp et al., 2017) and more recently in BPD (Martin et al., 2019).

Marková and Jaafari (2009) offered a notably clear definition of clinical insight: the aspect of insight related to awareness of the illness and its implications for therapeutic management. Accordingly, awareness of the disorder is the most measured aspect of insight, particularly using historical scales such as the Scale to Assess Unawareness of Mental Disorder (SUMD). After various explorations and considerations, Amador et al. (1993) established consensus around empirical measures of insight, and returned to a two-part conception: awareness of the illness and the ability to attribute a cause to the illness (for a review, see Marková & Jaafari, 2009).

3.4. Cognitive insight and metacognition for psychotherapy

The definition of cognitive insight was established by Beck and Warman (2004), who described patients’ ability to step back from their strange experiences, reflect on them, and adaptively respond to them. This concept was not separate from clinical insight in that it also influenced patients’ awareness of the illness, particularly in depression (Mass et al., 2012). Studies showed that clinical insight was a predictor of positive advances in psychotherapy, particularly in SZ (Riggs et al., 2010). Studies extending cognitive insight to other disorders, including BD, showed a similar level in both SZ and BD (Engh et al., 2007). One identified implication of insight concerns its role in danger (e.g., violence, aggression, hostility, impulsivity, and sexual assault) in psychiatry. A recent literature review tried to decide on this point, but unfortunately, given the heterogeneity of the methodologies, it was

impossible to conclude anything other than that further study was needed of the link between clinical insight and psychiatric dangerousness (Bonnet, Lacambre, Schandrin, Capdevielle, & Courtet, 2017). Nevertheless, this highlights the importance of insight into the behavioral dimensions of psychiatric disorders.

Cognitive insight predicted better outcomes of cognitive remediation and cognitive therapies for disorders other than SZ (Benoit et al., 2016). Several studies have shown that high levels of cognitive insight led to increased suicidal risk in SZ (for a review, see Amador et al., 1996; Crumlish et al., 2005; Kao & Liu, 2011; Palmer et al., 2015; Schwartz & Smith, 2004) and BD (de Assis da Silva et al., 2015; Yen et al., 2008). Indeed, while becoming aware of one's pathology could help one better cope with it, one should not forget that it can also encourage rumination and lead to a depressed mood (Thomas, Ribaux, & Phillips, 2014).

A consciousness-related concept like insight tends to be related to any cognitive ability to identify or perceive change or the need for change based on the capacity to detect and acknowledge that something is wrong.

Cognitive insight, through its psychopathological implications in terms of both predicting outcomes and its role in other dimensions (i.e., metacognition and cognitive processes), seems to be increasingly emerging as a key element in the search for dimensions to address in psychotherapy (for a review, see Van Camp et al., 2017).

3.5. Consciousness as a cognitive skill

Another field of psychology that questions the distinct aspects of consciousness is cognitive psychology, in which years of research have questioned how meta-processes should be defined and investigated (Sandberg et al., 2010) and distinguished from perceptual processes (Cleeremans et al., 2020; for a review, see Michel et al., 2019). Regarding this "metacognitive" part, i.e., the consciousness of others' state of mind, BPD problems seem relevant to study. Semerari et al. (2015) studied the "mindreading" ability of patients with BPD versus other personality disorders in a large sample. Patients with BPD had difficulties differentiating and integrating others' thoughts and states of mind, no matter their level of symptomatology. These results suggest a specific mindreading impairment in BPD and a strong relationship between this impairment and the severity of psychopathology. Semerari et al. (2005) had already assessed metarepresentation issues in BPD, proving that the patients retain their ability to distinguish mental states, but have difficulties integrating representations of themselves and others and differentiating between fantasy and reality. This seems consistent with the literature connecting BPD and psychotic symptoms (Schroeder et al., 2013). The starting point could be to work more on insight and metacognition.

New therapies based on cognitive issues and insight have started to develop (Lysaker & Dimaggio, 2014; Lysaker et al., 2018, 2019). Of these therapies, Metacognitive Interpersonal Therapy (MIT-G) was explored by Popolo et al. (2018) to address metacognition and insight, using them as problem-solving tools. They found symptomatic and functional improvements and an increased ability to understand mental states and regulate social interactions, suggesting that MIT-G could be of significant use in BPD. In SZ, Metacognitive Reflection and Insight Therapy (MERIT) started to emerge with Hillis et al.'s (2018) work. They fostered, in the patients, an integrated and realistic idea of their own identities and those of others, helping them to adapt their representations of the world and to respond effectively to life challenges. Insight and Metacognition Therapy is also expanding to BPD in different forms (Dimaggio et al., 2019), together with therapeutic alliance. Although no specific treatment has been launched for BD, there has been a call to use metacognitive beliefs as a treatment target for this disorder (Batmaz et al., 2021), as there is evidence of metacognitive impairments in BD (Favaretto et al., 2020; Popolo et al., 2017).

Schilling et al. (2015) started to implement metacognitive work as an add-on intervention for BPD in their Metacognitive Training for

Borderline Personality Disorder (B-MCT) patients, with satisfactory results. Bonfils et al. (2017) investigated the protective effect of metacognitive self-reflectivity on empathy and distress tolerance in SZ, but as these dimensions are two essential elements of BPD therapy, studying metacognition for BPD could be interesting. Vohs and Leonhardt (2016) found that impairments in metacognitive capacity are a core barrier to recovery from BPD. In a case study, they implemented metacognitive therapy for a BPD patient and found a significant decline in BPD pathology. The main impact was on the patient's interpersonal relationships with family and peers: the patient expressed decreased affective dysregulation and mood reactivity and decreased impulsivity.

Lysaker et al. (2018) compared metacognition issues in BPD, substance use disorder, and SZ. The BPD group had better self-reflectivity and awareness of others' minds than the SZ group, but less mastery and deceleration than the substance use group. BPD and SZ patients shared the same high alexithymia level, but no differences were found in emotion recognition. Metacognitive functioning seems to be impaired in both SZ and BPD. A recent meta-analysis proved that metacognitive impairments are widely represented across various psychopathologies (Sun et al., 2017).

3.6. The social aspect of consciousness: the largely ignored "self-consciousness"

Regarding consciousness experts' explanation of the core components of social psychology, these experts have their interpretations and definitions of consciousness to offer clinical psychologists now working in the frame of biopsychosocial therapy. Cleeremans et al. (2020) acknowledged the relationship between theory of mind, perceptual awareness, and self-awareness as part of the consciousness process we want to address. These authors clearly stated that the "social world is thus instrumental in generating conscious experience, for something special happens when we try to build a model of the internal, unobservable states of agents that are just like ourselves" (Cleeremans et al., 2021, p. 121). Here we also include a more specific measure of the "self-awareness" aspect we can measure from clinical psychology, integrating the social aspect of consciousness levels using the Self-Consciousness Questionnaire (SCS) (Fenigstein et al., 1975), which distinguishes private from public self-consciousness and includes a social anxiety measure.

In most disorders, one cognitive aspect that worsens any disorder by adding anxiety is social consciousness, the process that makes individuals overly concerned with judgment or feedback from others (e.g., people, society, and group members). When one experiences discomfort in a situation and feels inadequate, one may seek the reason for the shame or emotional discomfort, asking "What am I doing wrong?" This mechanism creates what we call self-conscious thought, when one repeatedly screens one's internal sensations, thoughts, and judgments to make sense of the social anxiety experienced. When exploring consciousness issues in psychiatric disorders, we may then consider this "social" aspect of awareness (Stein, 2015).

Considering the aspect of consciousness related to others' feedback can be relevant, as new therapies focus on social connectedness, therapies such as the recently developed transdiagnostic CBT protocols that use social consciousness skills to improve symptoms (Gilbert et al., 2020). The ability to understand the consequences of one's behavioral dysregulation comes from the consideration of others' feedback. We then need to assess insight and consciousness in light of the specific consciousness as self-consciousness in its public and private forms. Specialists in insight have also advocated the inclusion of social cognition factors: "Social cognition may be a crucial cognitive determinant of impaired insight in schizophrenia" (Konstantakopoulos, 2019 p. 1).

In an article examining a multidisciplinary aspect of self-consciousness, Ghoffar (2019) explained one of the more recent definitions of consciousness that encompasses its social aspect. Kalaiyaran and Solomon (2016) described self-awareness as the ability to be aware

of oneself through authentic evaluations of one's capacity, and the ability to recognize oneself as an individual separate from the environment and other individuals. Self-awareness also represents the capacity to be the object of one's attention. In a so-called social situation, when facing other humans, we tend to collect, interpret, and integrate information about ourselves (Morin et al., 2011).

Moreover, self-consciousness can be related to a sense of oneself and can impair identity; in SZ, for example, meta-analytic results proved that the sense of body ownership was disturbed, as was the sense of agency. Surprisingly, distortion in sense of agency came from exaggerated self-consciousness (Hur et al., 2014), once again questioning the "quantity" of consciousness that may be beneficial to the patient or, on the contrary, be iatrogenic.

4. Discussion

Different fields, as well as consecutive measures used in clinical psychology, do not consider the same issues of consciousness in different subcategories of so-called consciousness. This questions the need for a clear definition of consciousness as a more precise operational concept such as insight, metacognition, or self-consciousness, or as a newer definition of "consciousness" in clinical psychology.

It appears that we do not need our patients to be aware, mindful, insightful, or "conscious," but perhaps just motivated to change and somewhat knowledgeable about their dysfunctions.

Better understanding one's dysregulation can be obtained using the technique of psychoeducation, which is well established across psychiatric disorders. This educational intervention builds patients' understanding and knowledge of their disorders and has produced some results comparable to those of psychotherapy (Rabelo et al., 2021; Xia et al., 2011). Zhao et al. (2015) examined a brief psychoeducation intervention for people with serious mental illness, finding effects greater than or comparable to those of psychotherapy. Moderating these results, the relapse rate was lower in the short term with psychoeducation but higher in the long term compared with routine care. Interestingly, social functioning was also improved in a psychoeducation group in which a brief intervention educated psychiatric patients about the symptoms, treatments, and prognoses of their illnesses. The impact of such an intervention has been widely acknowledged in BD and SZ, but it remains to be explored in BPD, to compare its effectiveness with those of "consciousness interventions" such as insight and meta-cognitive therapies.

4.1. Consciousness is not a therapeutic

Mechanisms of change through psychotherapy have been studied from the psychoanalytic and psychodynamic perspectives in the 20th century, synthesized as the patterns of change identified as the identification, description, explanation, and prediction of process effects related to psychotherapeutic change (Rice & Greenberg, 1984). In one of the latest research projects exploring change in psychotherapy, Kramer et al. (2020) found that productive processes in psychotherapy could be of two sorts—evaluative (i.e., a dimensional construct) or descriptive (i.e., telling the clinician what to do when considering which process indicator)—questioning how to classify, for example, insight and metacognition. When considering "consciousness" as a process to maneuver, one may need more precision as to the type of leverage we are working on and for what purpose.

For example, in most types of psychotherapy, therapeutic alliance, cohesion, and good collaboration have proved to be the most crucial factors affecting change (Smith et al., 2006). In the personality disorder field, emotional change is a core aspect with a dedicated goal: improving emotion regulation, deepening emotional experience, cultivating emotional awareness, and fostering emotional transformation (Greenberg & Pascual-Leone, 2006). In addition, Kramer et al. (2020) also showed that socio-cognitive changes are an effective mechanism of

change, classifying metacognition together with interaction functions as processes denoting change in individuals' interactions with their environment. Regarding the "insight" process, however, evidence appears to be lacking.

The question is now whether to consider existing vocabulary use or to refer to more empirical concepts encompassed in the generic word "consciousness." For example, recent research has reflected on the difference between "consciousness" and "awareness" (Perrotta, 2020), questioning the importance of these concepts for change in psychotherapy. Indeed, we also question the need to use the word "consciousness." It refers to specific conceptions of conscious and unconscious processes developed in psychoanalysis but possibly irrelevant to the various word uses of clinical psychologists regarding the fact that their patients are not connected to the here and now, not motivated to change, and not adequately situated in their living environment (i.e., social place). Recent CBT techniques focus on the "here and now"; in acceptance and commitment therapy (ACT), for example (Kahl et al., 2012), psychotherapists have their patients eliminate any cognitive beliefs or filters that may prevent them from being connected to reality. Specialists in "third-wave" CBT elaborate on their approaches to incorporate mindfulness. For example, Hayes and Hofmann (2021) advocated a processual conceptualization of psychiatric issues as "psychological processes of change [that] can be organized into six dimensions: cognition, affect, attention, self, motivation, and overt behavior" (p. 363), to differentiate their consciousness-related work and define it more specifically and clearly.

Consciousness as a "must have" for any patient undergoing psychotherapy can be also considered a motivational need, as in "I need to be conscious of the issue to be motivated to change." More specifically, regarding motivation to change, the common use of the motivational status of the patient regarding change can be addressed by using CBT concepts of motivation (DiClemente et al., 2008), with the patient being evaluated as in the pre-contemplative, contemplative, or action implementation phase (Miller & Rollnick, 2012).

Regarding the social aspect of consciousness, specific skills can be measured to assess how patients interact and connect to their social environment. The social integration level can be measured using a social skills assessment (Riggio, 2005), and psychosocial rehabilitation and assertiveness tools can be well implemented in skills development programs.

Specific "consciousness" symptoms occurring when patients are disconnected from their reality can be described as dissociation, depersonalization, derealization, and hallucination, all states that occur when one is shut off from outside stimuli and one's perceptions come more from internal malfunctions than perception issues. The move toward a more common vocabulary, to avoid "mysterious" words such as "consciousness," may be relevant for improving patients' understanding of their cognitive processes and biases toward reality and for the clinician, who can step aside from the paternalistic psychoanalytical terminology of the "unconscious-conscious."

Finally, "insight" is another word that can be a synonym for "consciousness" or "awareness," although it also entails certain pitfalls (Rocha et al., 2021). The move to consider "insight" in psychiatry was an attempt to define consciousness in an "objective" manner. Poor insight has been linked to poor treatment outcomes and adherence issues in general, but insight can also be a double-edged sword, as it can have iatrogenic effects in mood disorders (de Jong et al., 2020).

4.2. Which "consciousness" goes with treatment adherence?

The literature confirms that the most relevant factor affecting treatment adherence in various disorders is metacognition—including in non-psychiatric disorders such as cancer (Butzbach et al., 2021; Hargis & Castel, 2018; Nejad et al., 2020). However, recent research into metacognition and cognitive insight in first-episode psychosis has revealed that cognitive insight may not be related to metacognition

(Alkan et al., 2020). Moreover, the clinical implications of the use of metacognitive dynamics to improve insight may merit more discussion, because a recent meta-analysis reported mixed results concerning the impact of metacognitive therapy on cognitive insight in schizophrenia spectrum disorders (Lopez-Morinigo et al., 2020).

These updates on consciousness in cognitive and behavioral therapy indeed indicate the metacognitive trend, promoting metacognition work to improve and enhance classical cognitive therapy for various disorders such as anxiety disorders (Wells, 1995), depression (Normann et al., 2014), and schizophrenia (Moritz & Woodward, 2007) interest of clinicians in consciousness goes beyond specific disorders to encompass the future of cognitive behavioral interventions, seeking a new mechanism of change in psychotherapy (Sajatovic et al., 2002). More research may be needed to address the precise question of metacognition's impact on treatment adherence per se in psychiatric care, as studied in other fields (Tayyar-Iravanlou, Mousavizadeh, Mohtashami, & Nasiri, 2022), to follow up on the growing literature treating insight as a factor predicting treatment adherence (Roux et al., 2023). Returning to the cognitive-attentional effects of metacognition as previously defined by Wells and Matthews (1996) could help us better describe the actual effectiveness of metacognition skills in different types of psychotherapy.

4.3. The need for multidisciplinary debate

Even if a promising definition of “consciousness” emerges, a broader definition extending to psychiatry, forensic care, and ethics needs to be developed at the same time, as the concept is strongly linked to other aspects of clinical psychology, such as the ethical aspects of patient freedom (Dennett, 2018) and responsibility (Kabigting, 2021). Creating a vocabulary for consciousness issues may have extended consequences. Further research will be needed to formulate a new definition of “consciousness” as a more practical concept dedicated to addressing change preparedness and willingness to face the ethical and legal implications at stake in psychiatric disorders and in questions of both autonomy and responsibility. Another approach would be to differentiate sentience from consciousness, as neurobiology and neuroscience long ago started to use sentience as a mechanism distinct from human consciousness (Cleeremans et al., 2020). One of the newest conceptualizations, presented by Cleeremans et al. (2020), is the self-organizing meta-representation account (SOMA) defining consciousness as the brain's theory of itself. It is based on three principles: 1) information processing via neurons is unconscious; 2) information processes are carried out gradually and in “cascades”; and 3) plasticity, i.e., the brain can evolve, be flexible in its form and responses. This novel model could help clarify the neuro-biological basis of “consciousness,” but clinical psychology needs to step in with proposals for applying the model in psychotherapy and for psychiatric disorder-specific issues. For example, recent developments in psychedelic drug implementation in psychiatry have replayed the “consciousness” wording debate in the medicine-based field of psychiatry, as researchers tend to treat changes in attention, body sensation perception, focus skills, and emotion regulation induced by substances as acting on changes in “consciousness” (Millière et al., 2018; Raffone & Srinivasan, 2010; Schmid et al., 2021) rather than in specific executive functions (e.g., attention, memory, and inhibition). The same applies to some research claiming that meditation practices work on “consciousness” or “full consciousness” rather than clarifying the biological, attentional, and cognitive functioning effects of medicalized mindfulness practices (Berghmans et al., 2010; Katyal, 2022; Manuello et al., 2016; Millière et al., 2018) or their impact on emotion regulation (even in inexperienced meditators; Basso et al., 2019). Moreover, research combining the two approaches of psilocybin-assisted mindfulness training and meditation could be more rigorously directed toward cognitive functioning, self-consciousness, self-perception, and brain functioning dynamics (Smigielski et al., 2019).

Most of the limitations of this article come from the need for an

expanded dialogue with other fields of psychology, such as neuropsychology, or with philosophers studying consciousness issues across medical and engineering disciplines. We invite further research to explore the effectiveness of “consciousness” in clinical psychology, as Del Pin et al. (2021) have done, and we welcome philosophical and ethical research within the psychiatric field to help clinicians improve their understanding of this jigsaw-like concept.

5. Conclusion

Describing the pragmatic use of “consciousness”-related measures and concepts may also help practitioners master their own insightful-ness. This would give them better responsiveness *in vivo* to each patient, a better experience of self and time (Wittmann, 2015), and improved relationships with their own sentience interoception (i.e., bodily self-perception that may be useful in emotional therapy).

Declarations of interest

None.

Role of the funding source

None.
No preregistration.

Authors contribution

SM, made substantial contributions to the conception and design of the work; the acquisition, analysis, and interpretation of data; drafted the work, revised it critically for important intellectual content; approved the version to be published; and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Non authors contribution

The author would like to express their gratitude to Wade E. Pickren for his guidance and advises during the writing of the paper.

Ethical statement

Not Applicable.

Declaration of competing interest

We declare no conflict of interest.

Data availability

No data was used for the research described in the article.

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