Insight in Opioid Use Disorder: A Person-Centered and Recovery-Oriented Reconceptualization

by
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Abstract

The United States is currently experiencing an “opioid epidemic” in which individuals are overdosing and experiencing opioid use disorder (OUD) at high rates (Lyden & Binswanger, 2019). Despite these mortality and morbidity rates, people with OUD have low service utilization rates. The present theoretical thesis aimed to explore potential reasons why people aren’t seeking services by examining psychosocial and structural factors associated with insight, often defined as problem recognition and motivation to seek help. Literature on clinical insight and general mental health is first reviewed, highlighting the consistency of findings indicating that clinical insight can lead to depression and demoralization through increased stigma (e.g., Cavelti et al., 2012). Research on insight and substance use disorder (SUD) is then reviewed, which indicated that people with SUD face unique structural and social circumstances and barriers that can impact insight. Finally, this thesis proposes a person-centered, recovery-oriented reconceptualization of insight in OUD that broadens the scope of factors understood to impact insight. This reconceptualization also focuses on how opportunities for personal growth and perceptions of a fulfilling life and recovery in the future might be inherent to insight, with a recommendation for clinicians to initially focus on facilitating growth and perceptions of a fulling future, rather than insight as classically defined.
Introduction

America is currently experiencing what has been deemed the “opioid epidemic,” a “nationwide public health crisis” (Lyden & Binswanger, 2019, p. 1) in which deaths from opioids have increased substantially, and individuals are experiencing high rates of opioid abuse. For example, deaths from opioids increased by 27% from 2015 to 2016 alone (Lyden & Binswanger, 2019). In 2016, more than 42,000 individuals in the United States died from an opioid overdose (OD) (Lyden & Binswanger, 2019) and, according to the most recent National Survey on Drug Use and Health, an estimated 2.1 million people in the U.S. 12 years or older had an opioid use disorder (OUD) within the past year (Ahrnsbrak, Bose, Hedden, Lipari, & Park-Lee, 2016). Even though OUD rates and the number of individuals overdosing are high, people with substance use disorder (SUD) in general have low service utilization rates. According to the 2016 National Survey on Drug Use and Health, only an estimated 1.8% of young adults aged 18 to 25 with a SUD received substance use treatment in the previous year, and only an estimated 1.4% of adults aged 26 or older with a SUD received treatment (Ahrnsbrak et al., 2016). This disparity between the number of individuals experiencing problems related to substance abuse and the number of individuals utilizing treatment points to a need to address why many individuals with SUD, and OUD in particular, are not using services that could aid them in recovery and maintaining abstinence or utilizing harm reduction services, which aim to help individuals to reduce substance abuse and harmful consequences related to substance abuse (Roozen & Van de Wetering, 2007), such as the contraction of hepatitis C or HIV/AIDS, car accidents, and ODs (MacMaster, 2004).
This reduction in substance abuse can be pursued in addition to abstinence as a goal (Roozen & Van de Wetering, 2007).

It is unclear why many people aren’t using services. One perspective on motivation to seek help derives from the transtheoretical model of stages of change (Prochaska & Diclemente, 1982). The transtheoretical model of stages of change purports that individuals move through various stages on the path to changing a problem. These changes represent a linear (although potentially cyclical) sequence of precontemplation, contemplation, preparation, action, and maintenance (Miller & Tonigan, 1996). According to this model, individuals must move through these stages, eventually garnering awareness of the problem and motivation to change (Miller & Tonigan, 1996). This model identifies problem acknowledgment as a necessary first step for motivation to change or, in relation to service usage, seeking services. Thus, in this view, in order to have the motivation to seek services, individuals must first acknowledge that they have a substance-related problem that needs to be addressed.

To date, research has examined whether individuals who have recently experienced a severe drug-related event, such as an OD, have increased problem recognition and subsequent motivation to seek help, with these two components together (problem recognition and motivation to seek help) hereafter discussed and referred to as insight. This definition of insight is similar to the operationalization of clinical insight commonly used in prior literature, which comprises having awareness of a psychiatric problem, symptoms, and the need for treatment (Kamens et al., in preparation). Research has also examined whether addiction severity, of which ODs
are one indicator, is associated with insight among opioid users. Although it would appear that a severe event or severe problem might spur an individual to have increased problem recognition and subsequent motivation to seek help, previous research has not consistently found that individuals have high levels of insight after a severe event or along with a more severe SUD or OUD. Thus, having a more severe problem or experiencing more severe drug-related events does not seem to contribute reliably to motivation to seek help and services. These findings fail to answer the question of what might be contributing to, or causing, particular levels of problem recognition and motivation to seek help, and low service utilization rates in general. Various psychological or structural factors might be contributing to particular levels of insight, such as hope, subjective quality of life (SQOL), the use of particular services, or satisfaction with services, among other factors. However, relationships between insight, and various psychological and structural factors among individuals with OUD who have recently overdosed, have been underexamined in research.

Clinical insight has been associated (though not always consistently) with numerous important variables in individuals with various psychiatric disorders, such as treatment adherence, perceived stigma, depression, hopelessness, and SQOL. Our knowledge would benefit from examining the impact of similar factors on insight in individuals with SUD and, more specifically, individuals with OUD. These factors might similarly be impacting insight among people with OUD, and their service utilization rates. For example, research on the clinical insight of people with schizophrenia indicates that people with greater insight experience greater depression and demoralization. These higher levels of depression and demoralization in people
with greater insight are due to the perceived stigma they often experience as a result of acknowledging their diagnosis. Thus, it might be the case that people with OUD may not indicate that their problem exists, or that they need treatment, for fear of stigmatization, even if their insight might technically be intact. This is one example of a psychosocial factor that might be preventing problem acknowledgment and subsequent service seeking, with other factors potentially influencing insight as well.

Currently, neuroscientific research is being conducted in which individuals with SUD in general are typically found to be neurologically impaired in their ability to recognize their SUD and behaviors associated with it. However, conceptualizing lack of insight as solely a neurological phenomenon doesn’t address other psychosocial or spiritual factors that have been examined in relation to psychiatric disorders other than SUD that might impact insight. As Kampman & Jarvis (2015) stated, “addiction should be considered a ‘bio-psycho-social-spiritual illness’ ” (p. 361). Therefore, research would also benefit from examining, for example, psychosocial correlates or predictors in addition to neurological correlates or mechanisms of insight, in order to ascertain a broader view of what might be impacting people’s perceptions and acknowledgment of their problem, as well as their drive to seek help to address their challenges.

Society and individuals with OUD are affected by this dearth of research. Both are affected by the lack of knowledge regarding the nature of insight among individuals with OUD due to, for example, the cost to the healthcare system and people seeking services due to inpatient and Emergency Department (ED) visits for substance abuse, as well as the aforementioned OD rates. They are also affected in the
sense that there is a gap in our knowledge about factors that might increase or reduce the likelihood of an individual wanting to acknowledge their problem or seek help, and subsequently seek services. These factors, or the phenomena they are associated with, might be addressed with clients or targeted in interventions in order to help individuals gain motivation for recovery or, conversely, to understand in which cases targeting insight might not be effective or useful. Research on the psychological and structural factors related to insight has the potential to affect psychological treatments or interventions offered to individuals with OUD after an OD. Such research could also help engage individuals in a meaningful recovery, which has implications for reducing substance-related challenges, such as symptoms, ODs, and low SQOL, that are often associated with OUD, as well as the overall prevalence rates of OUD.

Engaging in a meaningful recovery could involve the use of harm reduction services and/or the pursuit of abstinence, engagement in personally relevant and valued activities, setting and reaching goals, and participation in community and social life, depending on the individual’s goals, unique needs, and particular circumstances. This view of recovery as dependent on people’s unique needs and freedom of choice is in line with a person-centered approach to care, which, according to Talerico, O’Brien, and Swafford (2003), involves a responsibility of care providers to “respect the individual’s values, preferences, and needs” (p. 14), view the individual as a free agent with the ability to choose the care they receive, and understand the person in a biopsychosocial manner that is sensitive to individual characteristics. This person-centered approach is also in line with the conception of recovery in mental illness (Davidson & Roe, 2007), in which individuals themselves define what being in
recovery means as according to their unique needs and goals. Due to this individually defined conception of what recovery will entail, total symptom remission or abstinence is not necessary to enter recovery in this model, as the person is in recovery when they say so. This person-centered conception of recovery is the conception of recovery that will be used in this thesis. Finally, this research has implications for an overall improved understanding of individuals with OUD and their unique challenges and needs.

This thesis first offers a review of the literature on the nature of clinical insight, as well as its relation to treatment engagement, symptom severity, stigma, and SQOL among people with various psychiatric disorders. The broader literature on clinical insight is, overall, inconclusive. However, prior research demonstrates consistent indications that clinical insight can often negatively impact individuals due to internalized stigma related to acknowledging the psychiatric disorder, and the subsequent hopelessness and demoralization that can result. This section is followed by a review of the literature on insight and similar variables specifically among individuals with SUD, such as addiction severity, SQOL, perceived stigma, and service utilization. Additional variables to be reviewed are OD, post-traumatic growth (PTG), hope, and service satisfaction, with a brief review of neuroscientific research on insight, as defined in numerous ways in neuroscientific literature, and SUD. Prior research on insight in people with SUD overall indicates that people with SUD experience unique psychosocial and structural challenges that can impact insight. The final part of this thesis presents a synthesis of specific research conducted on insight and SUD, with the aim of providing an explanation for the nature of insight in people
with OUD in general and after an OD. The synthesis incorporates findings on the impact of numerous psychosocial and structural factors on insight. It argues for a person-centered and recovery-oriented reconceptualization of insight in SUD, which involves particular attention to these unique psychosocial and structural concerns in relation to insight and personal growth and development, as well as an initial focus on understanding what the person would like out of life and recovery. This reconceptualization of insight will be reached by outlining the unique structural, social, and personal circumstances that individuals with SUD and OUD commonly face. The thesis concludes with suggestions for future research and implications.

**Literature Review**

**Significance of Clinical Insight in General Mental Health**

There have been numerous mixed positive and negative associations, predictions, and differences in relation to clinical insight among individuals with varying psychiatric diagnoses. Clinical insight has been examined in relation to treatment engagement (O'Brien, Fahmy, & Singh, 2009), symptoms of severe mental illness (Cavelti, Rusch, & Vauth, 2014; Fu et al., 2017), depression (Depp et al., 2014; Murri et al., 2016), and, recently, stigma and demoralization (Cavelti, Kvgic, Beck, Rusch, & Vauth, 2012), among other variables.

**Treatment engagement.** Clinical insight has often been examined in relation to continued engagement with treatment with mixed results. For example, a literature review by O’Brien, Fahmy, and Singh (2009) showed that higher levels of insight were related to less disengagement with services among individuals diagnosed with psychosis. Similarly, Sajatovic et al. (2009) found that individuals diagnosed with
bipolar disorder (BD) who were nonadherent with medication treatment had lower insight than individuals diagnosed with BD who were adherent, suggesting that individuals with higher insight are more likely to adhere to medication treatment and, hypothetically, improve. Similarly, higher insight is associated with a better response to behavioral treatment specifically among individuals diagnosed with obsessive compulsive disorder (OCD) (Alonso et al., 2008).

However, in another study, individuals diagnosed with OCD who were taking medication had higher insight levels than those who were not taking medication, but they found no relationship between insight and psychotherapy adherence (Shimshoni, Reuven, Dar, & Hermesh, 2011). Therefore, the studies of Alonso et al. (2008) and of Shimshoni et al. (2011) differ in terms of the relationship between insight and adherence to treatment, depending on the treatment type. Additionally, higher insight has not always been connected to increased service engagement; among individuals with schizophrenia, those with lower levels of service engagement had higher insight and higher depression (Murri et al., 2016), suggesting that service engagement is an important aspect when considering the positive relationship between insight and depressive symptoms. In this study, insight was not only linked to worse psychological states but less engagement with services, suggesting that the influence of insight on treatment engagement for varying psychiatric populations isn’t clearly established.

**Symptom severity.** Clinical insight has often been studied in relation to specific psychiatric symptoms among differing psychiatric populations. In relation to OCD specifically, evidence regarding a consistent relationship between clinical
insight and symptom severity is mixed. Alonso et al. (2008) found that, among individuals diagnosed with OCD, there was an inverse association between severity of illness and insight, such that individuals with higher insight had a lower severity of illness. Elvish, Simpson, and Ball (2010) also found an inverse relationship between insight and severity of illness, such that among individuals with clinical levels of OCD, higher anxiety, more comorbid mental health challenges experienced, and more ordering compulsions all predicted lower insight. However, in a study focusing on individuals diagnosed with OCD, there was no relationship between symptom severity and insight (Shimshoni et al., 2011). Due to these mixed results, it is unclear whether higher clinical insight is reliably associated with, or can reliably predict, lower symptom severity in OCD.

Clinical insight has also been assessed among individuals with BD with more consistent results, although few studies have been conducted. Among individuals diagnosed with BD specifically, worse insight was associated with greater mood, speech, and thought/language-related symptoms (de Assis da Silva, Mograbi, Bifano, Santana, & Cheniaux, 2016). Insight into symptoms specifically was also negatively associated with these symptoms as well as agitation and energy. Similarly, Depp et al. (2014) found that, among individuals with BD, severity of manic symptoms was negatively associated with insight. More specifically, longitudinal analyses conducted by Depp et al. (2014) demonstrated that severity of manic symptoms negatively predicted insight over time (lower insight didn’t predict higher severity, in contrast). Thus, the relationship between higher insight and lower severity of symptoms is more
consistent in individuals with BD, albeit potentially due to the limited amount of research conducted on this population.

In terms of schizophrenia specifically, clinical insight has typically been thought of as related to numerous positive outcomes, including reduced symptoms; for example, among homeless patients with severe mental illness in China, better insight was related to less severe positive and negative symptoms (Fu et al., 2017). However, in a different study, higher insight didn’t predict lower symptoms or higher role functioning after one year in people diagnosed with schizophrenia (Cavelti et al., 2014). Thus, evidence for the relationship between insight and symptom severity in schizophrenia is inconsistent.

**Depression.** Additionally, an “insight paradox” has recently been identified, in which a positive association between clinical insight and depression has been found to exist among individuals diagnosed with psychosis (Murri et al., 2016). In a meta-analysis, Murri et al. (2015) found that three dimensions of insight (awareness of illness, symptoms, and understanding of their causes), were all positively correlated with depression in individuals diagnosed with schizophrenia. Insight into the need for treatment specifically, however, was not correlated with depression. Murri et al. (2015) also found that insight positively predicted depression over time by examining longitudinal studies among individuals diagnosed with psychosis. Thus, this study indicates with a high probability that individuals diagnosed with psychosis who have higher insight are likely to show increasing levels of depression over time, a finding that contradicts the hypothesized positive benefits of insight in relation to lowered symptomatology. Furthermore, Murri et al. (2016) found that severity of illness
moderates the relationship between insight and depression, such that the higher the
level of illness severity, the stronger the positive relationship between insight and
depression. In this sense, higher levels of clinical insight are particularly detrimental
in terms of depression for those who are experiencing more severe levels of illness.

Other studies have reported this association as well as mediators of the
relationship; the positive relationship between insight and depression among
individuals diagnosed with psychosis has been found to be mediated by increased
hopelessness (Murri et al., 2016). The positive relationship between insight and
depression among individuals diagnosed with psychosis has also been found to be
mediated by higher perceived discrimination (Murri et al., 2016). Murri et al. (2016)
also found that individuals with a lower socioeconomic status had more insight and
depression. Furthermore, Cavelti et al. (2012) found that higher insight predicted
higher demoralization after one year among individuals diagnosed with
schizophrenia. This relationship between higher insight and higher demoralization
was moderated by self-stigma, such that individuals with high levels of both insight
and self-stigma had higher levels of demoralization than individuals with high insight
but low self-stigma (Cavelti et al., 2012). Thus, high clinical insight may only be
associated with increased demoralization if the individual diagnosed with
schizophrenia also has high levels of self-stigma.

Depp et al. (2014) found that this “insight paradox” also seems to hold among
individuals with BD; higher insight at baseline positively predicted higher depressive
symptoms over time. However, this is the only study the author knows of which
assessed the phenomenon in individuals with BD, so it is uncertain whether the
positive relationship between insight and depression is replicable in people with BD. This correlation has also been examined in individuals experiencing eating disorder (ED). However, Konstantakopoulos, Tchanturia, Surguladze, and David (2011) found that insight was not correlated with depression or anxiety, which the authors suggest might be due to perceived positive psychosocial benefits resulting from the ED.

These studies indicate that the link between higher insight and higher depression is consistent depending on the population assessed. In relation to BD specifically, research has found a link between insight and depression. However, in individuals with ED, there is no relationship between insight and depression. Even though prior research has found a positive relationship between insight and depression in people with BD, and no relationship between insight and depression in ED, the relationship between insight and depression in either disorder has been grossly underexamined by prior research and, consequently, determinations in terms of the consistency of this relationship in either disorder cannot be made. However, among individuals diagnosed with psychosis, the correlation between insight and depression is generally consistent and mediated by higher stigma, higher hopelessness, and higher discrimination. The link between higher insight and higher demoralization, however, may only pose problems for those who experience higher levels of both insight and self-stigma.

Discovering a community of others with similar challenges; self-empowerment. Although the positive correlation between insight and depression specifically indicates negative effects of accepting a psychiatric diagnosis for particular populations, several studies have found that identifying with a diagnosis
can have positive benefits, such as an increased possibility of finding a community
and subsequent social support that it might offer, as well as increased validation and
self-empowerment through the increased knowledge a diagnosis might bring. For
example, in a review of the literature on challenges related to acceptance of a
psychiatric diagnosis, Corrigan and Rao (2012) report numerous studies showing
positive benefits of accepting a psychiatric diagnosis, like lower reductions in quality
of life due to reduced self-stigmatization among individuals with serious mental
illness (SMI). Corrigan and Rao (2012) also cite the existence of particular peer
programs that people with psychological challenges, by identifying with and
disclosing their diagnosis, can use to seek support. They cite an evaluation of
consumer-operated services that showed increased perceptions of empowerment, as
well as self-reliance, independence, and coping skills through work with others with
similar psychiatric diagnoses or challenges (Corrigan & Rao, 2012). Similarly, in
relation to diagnoses and facilitation of social support, a literature review of
qualitative studies found that participants across studies, in adjustment to diagnoses,
reported the facilitation of joining new social networks, as well as feelings of
connection with others experiencing similar challenges (Perkins et al., 2018). The
authors also found that the most common theme for service users was disclosure as a
pivotal moment; more specifically, service users reported relief, feelings of validation
of their experiences, and greater empowerment and self-knowledge gained through
diagnosis reception (Perkins et al., 2018).

Kranke, Floersch, Townsend and Munson (2010) also found that, among
adolescents diagnosed with a psychiatric disorder, although the adolescents felt
limited in terms of potential friend groups they could associate with due to their disorder, they were able to form empathetic relationships with peers who also acknowledged similar psychiatric conditions. Through these relationships, adolescents experienced increased feelings of being understood (Kranke et al., 2010). Thus, adolescents were able to develop beneficial relationships with others by acknowledging the disorder they were diagnosed with. Kranke et al. (2010) also found that several adolescents reported behavioral improvement, such as less anger, more enjoyment, and academic improvement. Thus, although the positive correlation between higher insight and higher depression might be consistent among individuals diagnosed with psychosis, it is the case that individuals with other diagnoses, as well as some individuals experiencing psychosis, can experience positive effects due to acknowledging their diagnosis. People may also experience positive effects in tandem with negative effects, such as depression.

**Subjective quality of life.** Finally, clinical insight has commonly been assessed in relation to SQOL, specifically among individuals diagnosed with psychotic disorders. Several studies report an inverse relationship between insight and SQOL. Specifically, Hasson-Ohayon, Kravetz, Meir, and Rozenewaig (2009) found that low levels of hope mediated the inverse relationship between higher insight and lower SQOL among individuals diagnosed with schizophrenia and schizoaffective disorder. Similarly, Boyer et al. (2012) reported that, among individuals diagnosed with schizophrenia, lower SQOL was associated with a higher awareness of a mental disorder. However, Boyer et al. (2012) also found that higher SQOL was associated with both higher awareness of positive and negative symptoms, indicating that the
relationship between insight and SQOL might differ depending on what insight is assessed as into. In this study, higher insight was related to lower SQOL only when the individual was aware of having a disorder specifically, rather than aware of specific symptoms of the disorder.

A positive relationship has also been discovered between insight and SQOL among individuals diagnosed with psychosis and other disorders; in relation to individuals with psychotic disorders specifically, higher clinical insight at baseline predicted higher SQOL, although this was found after a cognitive training intervention (Burton, Vella, & Twamley, 2011). Furthermore, Fu et al. (2017) found that homeless individuals in China with good insight, regardless of schizophrenia diagnosis or otherwise, had higher physical component scores on the SQOL scale than those with low insight, with no differences in the mental component scores. Thus, studies show mixed results when assessing how insight and SQOL are associated, although the negative association between awareness of a mental problem specifically and SQOL appears consistent among individuals diagnosed with schizophrenia.

**Significance of Insight in Substance Abuse**

Although the relationship between clinical insight and various psychological and structural factors has been assessed in psychiatric disorders such as schizophrenia, OCD, and BD, this area of research is relatively underexamined in individuals diagnosed with SUD more generally, and OUD in particular. Given the mixed findings among individuals diagnosed with varying psychiatric disorders regarding insight and treatment engagement, symptom severity, depression, and SQOL, and the
importance of these variables in relation to treatment and psychological distress, research could benefit by assessing these variables, and determining whether findings are also mixed, among individuals with SUD and OUD.

**Addiction severity.** One variable that has been measured in relation to insight in individuals experiencing SUD is addiction severity. Evidence linking problem severity to awareness of challenges or motivation to seek help is mixed, however. For example, individuals who more strongly identified with having an alcohol problem, but not necessarily more motivation to change, were found to experience more substance use challenges (Miller & Tonigan, 1996). Similarly, Duffett and Ward (2015) found that problem recognition positively predicted global ASSIST scores, a measure of substance-related problem severity, and taking action steps negatively predicted problem severity over time; this relationship remained stable over the 6- and 10-week follow-ups. Another study (Probst, Manthey, Martinez, & Rehm, 2015) aiming to ascertain the reasons why individuals don’t seek treatment, found that as alcohol use disorder severity increases, individuals had greater awareness of substance-related challenges but reported experiencing barriers to treatment seeking, such as reduced trust in treatment providers or problems finding providers. For individuals with lower severity, the absence of identifying with having an alcohol problem prevented participants from seeking treatment (Probst et al., 2015).

However, Miller and Tonigan (1996) found that both increased recognition of an alcohol-related problem specifically, as well as taking action steps to help the problem, were correlated with higher total alcohol consumption, although the correlation between taking action steps and alcohol consumption was very weak.
Finally, in a study of heroin and methamphetamine coinjectors, coinjectors (indicating a high severity of substance-related challenges) were more likely to report needing help for their drug use than individuals who did not coinject both methamphetamine and heroin (Meacham et al., 2016).

Very few studies have examined relationships between the severity of a substance-related problem and insight. Research that has been conducted so far has generally found that addiction severity is associated with problem recognition, but not motivation for treatment or motivation to take steps to fix the problem, which might be due to perceived barriers, as reported by Probst et al. (2015). It might be the case that greater substance use challenges lead to identification with having a problem but not more motivation to seek support, even if a person desires support, due to barriers in seeking treatment or obtaining treatment that the individual deems appropriate or perceives as potentially helpful.

**Overdose.** One specific factor of addiction severity is OD. Individuals with OUD are at risk of overdosing, and due to the serious nature of an OD event, it is possible that an OD facilitates recognition of substance-use challenges and motivates individuals to seek help. However, research to date does not clearly indicate motivating effects of OD or increased problem recognition. Kerr, Small, Hyshka, Maher, and Shannon (2013) found that many injecting drug users felt ambivalent about future ODs due to their perceived low likelihood, even if the user had overdosed in the past. Thus, drug users may not perceive the OD as a likely future event and, accordingly, a facilitator of problem recognition or a motivator for treatment. Similarly, in another study (Zador, Sunjic, & McLennan, 2001), most
participants were not worried about a potential future OD; only 38% indicated that they planned to stop using after their most recent OD, and only 11% indicated that they would seek treatment such as rehabilitation or medication management. Thus, these two studies by Kerr et al. (2013) and Zador et al. (2001) indicate that ODs on their own, as one indicator of addiction severity, are not linked to either increased awareness of the substance-related problem or the need to seek treatment. Other than the previously mentioned studies, there is little research on whether experiences of OD are linked to problem awareness and motivation to seek help for the problem, and any additional factors that might affect the individuals’ insight after an OD.

Roozen and van de Wetering (2007) emphasize that relapse is a distinguishing feature of addiction, and thus that solely championing the cause of abstinence is actually harmful for individuals with SUD. Although the aforementioned studies didn’t assess subjective perceptions of how the OD might have affected perceptions of the future possibility for recovery, it might be the case that dominant models that promote abstinence might influence individuals to be more ambivalent about seeking treatment, as well as the severity of the problem, due to a low perceived probability of receiving adequate help and care and, thus, maintaining abstinence. This is an underexamined area that would benefit from increased research due to current high rates of opioid ODs specifically.

Post-traumatic growth. Due to the paucity of research on perceptions of ODs as a severe event, it is unclear whether individuals with SUD reliably perceive ODs as low in severity or likelihood. The severity of overdosing, however, in terms of increased risk of death indicates that ODs pose serious life challenges. One field of research
that examines experiential perceptions after severe events is PTG. Research on PTG, which is “the experience of positive change that occurs as a result of the struggle with highly challenging life crises” (Tedeschi & Calhoun, 2004, p. 1), has identified experiences of personal growth, meaning, strength, and shifted priorities in life, as well as a “richer existential and spiritual life” (p. 1), after experiencing and struggling to deal with “trauma, crisis, [and] highly stressful events” (p. 1). In a meta-analysis, PTG was found to be associated with positive benefits, such as less depression and higher well-being (Helgeson, Reynolds, & Tomich, 2006). Although not directly related to insight, PTG is conceptualized as involving subjective reformulations of the individuals’ positionality in life and subsequent understandings derived from experiential challenges after a highly stressful event. In this sense, PTG might represent a form of insight into personal conceptions of meaning and purpose in life, which ultimately helps aid individuals in coping with challenging life events.

PTG in relation to individuals with SUD specifically is an under researched area; in one of the few peer-reviewed studies found on PTG among individuals recovering from SUD, higher PTG was associated with higher willingness to seek help (Haroosh & Freedman, 2017). PTG in Haroosh and Freedman’s (2017) study was conceptualized as having occurred due to recovering from the challenges of addiction, and involved recognition of possibilities, changed relationships, meaning-making, spiritual and personal development, and a greater appreciation of life. In another study on PTG in individuals with a history of trauma, higher substance use was associated with lower PTG, whereas higher PTG, in addition to being related to lower substance use, was related to higher levels of approach coping, which included
positive reappraisal, problem solving, logical analysis, seeking of guidance and support, and seeking alternative rewards (Stump & Smith, 2008).

The relationship between PTG and willingness to seek help among individuals who have recently overdosed hasn’t been examined yet, but it might be the case that individuals may feel more motivated to seek help post-OD if these various aspects of growth are capitalized on and/or facilitated soon thereafter or, rather, individuals who have experienced previous periods of abstinence might have experienced PTG and thus might remain motivated to continue treatment and not feel demoralized by perceiving the OD as a setback or failure.

**Subjective quality of life.** Another important variable examined in populations with SUD is SQOL. Laudet, Becker, and White (2009) found that, among individuals in remission from substance-related challenges, higher SQOL predicted a higher likelihood of abstinence at one and two year follow-up, with this prediction partially mediated by motivation to remain abstinent (operationalized as commitment to abstinence). Although potential relationships between insight and SQOL in individuals with SUD, and OUD in particular, haven’t yet been fully elucidated, the relationship between SQOL and substance use challenges has consistently found that, overall, individuals with substance use challenges have a lower SQOL than the average population (e.g., Diaz-Moran et al., 2015; Manning et al., 2012; Saarni et al., 2008), with Saarni et al. (2008) finding that both individuals with severe alcohol-related problems and individuals in recovery from alcohol-related problems scored lower on SQOL than individuals without substance-related challenges who abstain from alcohol. Additionally, in individuals with drug, alcohol, and gambling disorders,
individuals with drug use problems had the lowest SQOL, specifically in terms of a lower standard of living, personal achievement, safety, connection with the community, and future security (Manning et al., 2012). Manning et al. (2012) also found that higher addiction severity predicted lower SQOL scores. Thus, the relationship between increased substance use challenges and reduced SQOL appears to be consistent, as indicated by the aforementioned studies.

The relationship between insight and SQOL among substance abusers is an under researched area, although Laudet et al.’s (2009) study did show that higher SQOL predicted abstinence, with commitment to abstinence as a partial mediator; since substance abusers overall have a low SQOL, research would benefit from the elucidation of whether low overall SQOL in substance abusers affects individuals’ motivation to acknowledge the problem and, consequently, seek help for the problem.

**Perceived Stigma.** Perceived and internalized stigma are additional factors that have been examined in relation to individuals with SUD, although the relationship between perceived stigma and insight hasn’t been examined yet. Perceived stigma is defined by Birtel, Wood, and Kempa (2017) as the individual’s perceptions of the public’s view of them, and internalized stigma as “the self-application of stigmatizing beliefs” (p. 1). Research has demonstrated that individuals with SUD do experience perceived stigma, and this stigma is related to negative psychological states. For example, higher perceived stigma regarding a substance-related diagnosis was associated with worse mental health, specifically lower self-esteem, worse sleep, and increased levels of depression and anxiety, with these relationships mediated by higher levels of internalized stigma (Birtel et al., 2017). Similarly, in a study
examining correlates of internalized stigma in people who inject drugs, higher internalized stigma was associated with higher levels of depression, increased severity of substance dependence, and less self-esteem (Cama, Brener, Wilson, & von Hippel, 2016).

Perceived stigma, and its relationship with distressing psychological states, has been found to be affected by levels of social support. For example, Birtel et al. (2017) found that higher perceived social support was associated with less depression and anxiety, as well as better sleep and self-esteem, with these relationships mediated by lower internalized stigma. Additionally, lower levels of perceived social support were found to mediate the relationship between higher perceived stigma and the persistence of alcohol use disorder (as measured by participants meeting the criteria for a DSM-V diagnosis for alcohol use disorder within the past year), with this relationship larger for individuals who were labeled (either received alcohol-related treatment or indicated unmet treatment needs involving acknowledged alcohol-related problems) vs. unlabeled (Glass, Mowbray, Link, Kristjansson, & Bucholz, 2013). Thus, stigma is an important factor in consideration of negative psychological states (like depression), as well as greater substance-related challenges.

Although the relationship between perceived stigma and insight specifically hasn’t been assessed, perceived stigma involves an awareness of substance-related problems. It thus might be the case that greater awareness of substance-related problems specifically, as one aspect of insight, might be related to higher perceived stigma and, consequently, negative psychological states which might further affect substance abuse. Furthermore, individuals have been found to benefit from social
support, as support is associated with reduced stigma. Thus, it might be the case that perceived social support might help mitigate potential effects of insight on negative psychological states and problem severity. Perceived or internalized stigma might also factor into motivation to seek help, although more research is needed in this area.

**Neuroscientific perspectives.** Another field of research in which insight in individuals with SUD is increasingly being examined is neuroscience. This field of research offers neurobiological explanations for the cause and maintenance of SUD, as well as the lack of insight in SUD and OUD. There are several neuroscientific theories that explain the cause or maintenance of SUD, with some implicating a lack of problem awareness as driving substance abuse behaviors. Further, individuals experiencing substance-related challenges are generally considered to be impaired in awareness of illness or symptoms because of neurological challenges that might leave individuals incapable of experiencing awareness of the problem and associated phenomena, such as drug cravings. However, these neuroscientific perspectives are limited in their capacity to address the impact of psychosocial or structural factors on insight, and therefore can’t adequately address the nature of insight in OUD alone.

One perspective on the maintenance of SUD involves attentional bias, which has been suggested as one important dysfunctional cognitive inclination that orients individuals toward substance-related cues, which then drives them to relapse (Franken & van de Wetering, 2015). This attentional bias is not conceptualized as one of which the individual is aware. Another theory that explains neurological and behavioral risk factors for developing SUD involves individuals as taking risks because of potential benefits, and not in consideration of costs (Franken & van de
in Wetering, 2015). This risk-taking during behavioral tasks has been demonstrated in individuals who aren’t addicted, but are at high risk of becoming addicted, and has been found to be related to increased activity in the anterior cingulate cortex and caudate nucleus (Franken & van de Wetering, 2015). Risk-taking has also been linked to decreased activity in the nucleus accumbens (Franken & van de Wetering, 2015).

Similarly, impaired error-processing has been implicated in the maintenance of SUD, in which individuals who experience substance-related challenges are not sensitive to, or perhaps aware of, consequences that could potentially arise due to their behavior (Franken & van de Wetering, 2015); this dysfunction in error-processing is again related to dysfunctional brain mechanisms, with the brain showing less activation during error-related tasks and subsequently less learning and improvement (Franken & van de Wetering, 2015). This dysfunction in error processing has been linked to the medial prefrontal cortex. Finally, inability to control oneself when using has been conceptualized as the underlying cause of SUD; previous studies have found that individuals with SUD have a dysfunctional right lateralized inhibitory network (Franken & van de Wetering, 2015). Thus, individuals in this case might be aware of a problem but unable to control it.

In terms of theories aiming to explain insight in SUD directly, theories of impaired insight involve a lack of inhibitory control, increased cravings and a subsequent unawareness of cravings, and impairments in episodic memory. For example, Moeller et al. (2014) found that, among individuals diagnosed with cocaine use disorder, those with impaired insight had lower error-induced rostral anterior cingulate cortex (rACC) activity, less gray matter within the rACC, and lower levels
of emotional awareness scale scores; insight in this study was measured by participants’ performance on an inhibitory control task. In terms of unawareness of cravings, in a literature review, Goldstein et al. (2009) summarize impaired insight in individuals with addiction problems as due to abnormalities in the anterior insula, which drives cravings and impairs awareness of illness severity as well as awareness of cravings. The authors conceptualize drug addiction itself as a lack of ability to recognize drug-related cues, which leads individuals to believe that they have control over their behavior. In relation to impairments in episodic memory, Le Berre and Sullivan (2016) defined insight as the awareness of episodic memory impairment; they cite impairments in insight as likely due to dysfunctional “posterior parietal and medial frontal regions” (p. 420), which are crucial parts of the Default Mode Network (DMN), as well as dysfunction in the insula, which results in reduced capability of switching between the DMN and the Central-Executive Control Network.

As these studies indicate, insight in relation to substance abuse is conceptualized and operationalized in a multitude of ways and linked to different regions of the brain. In general, neuroscientific theories explaining the cause and maintenance of SUD, as well as neuroscientific findings explaining the lack of insight, implicate a lack of awareness as due to a neurological impairment and, consequently, a brain dysfunction that individuals might not be able to easily control.

**Clinical applications.** Clinical applications of these neuroscientific models of insight are just beginning to be undertaken and, to date, several recommendations have been made for incorporating neuroscientific findings into clinical practice. Ray (2012) outlined several clinical implications for the incentive sensitization model
(Robinson & Berridge, 2001) specifically. The incentive sensitization model posits that incentive salience, a process of drug wanting that is not necessarily conscious, is attributed to drugs and associated cues due to the release of dopamine as a result of drug intake, which prompts individuals to have an increased drive to take drugs when they encounter drugs or associated cues (Robinson & Berridge, 2001). Potential clinical implications outlined include psychoeducation in which individuals identify and learn to cope with triggers (cues) by preventing conditioned responses, and behavioral interventions, such as introducing ways to refuse and avoid drugs. Ray (2012) also discusses emphasizing abstinence and long-term recovery to patients, due to the potential for drugs of abuse to alter neurochemical pathways, and the possibility of recovery to restore those pathways.

*Implications for individuals’ inability to have insight.* In general, these studies orient toward a conceptualization of a lack of insight among individuals experiencing substance abuse challenges as due to structural and functional neurological impairment. However, this conceptualization doesn’t account for other variables that might affect insight, such as psychosocial factors. Hunt (2014) emphasized that research on addiction “now incorporate[s] psychological, neurobiological, genetic, environmental, social, and spiritual considerations” (p. 57), and that “Addiction has thus become a multi-disciplinary construct that necessitates a wide range of understanding” (p. 57). Therefore, viewing the lack of insight in relation to SUD as a solely biological phenomenon can’t address the psychosocial aspects that contribute to insight and substance abuse.
**Person-centered/subjective perspectives.** Although insight in substance abusers is often conceptualized in biomedical or neuroscientific terms, the literature points to a need for a more person-centered understanding of individuals’ awareness of challenges. As previously outlined, addiction severity has been linked to one aspect of insight (problem awareness), but not motivation to seek help for the acknowledged problem, which indicates that treatment might not be perceived as potentially helpful. Additionally, perceived stigma is linked to psychological distress for individuals with SUD, which might impact insight, and low SQOL might inhibit motivation to seek treatment. Thus, neuroscientific understandings are limited in their capacity to assess psychosocial factors, such as perceived stigma, SQOL, and perceived efficacy of future treatment options, among others.

PTG has not commonly been applied to substance abuse, yet this field of research can offer a heuristic of a more holistic understanding of personally derived meanings and challenges experienced. Individuals with substance-related challenges might not solely be “constitutionally incapable of being honest with themselves” (*Alcoholics Anonymous: The Story*, 2001), as Alcoholics Anonymous (AA) groups might purport some individuals are, or solely neurochemically or structurally impaired, but rather likely encounter barriers to treatment or problem acknowledgment due to psychological or structural factors experienced due to their environment, sociocultural influences, and perceived ability to benefit from services that are offered and possible to obtain.

**Substance abuse and service utilization.** Overall, individuals with substance use challenges have low service utilization rates, which has been proposed to be due to
low insight. In a national epidemiologic survey conducted in 2001-2002, Compton, Thomas, Stinson, and Grant (2007) found that twelve-month treatment rates of substance abuse and dependence were 6.1% and 30.7%, and lifetime substance abuse treatment rates were 8.1% for substance abuse and 37.9% for dependence. This survey also identified rates of utilization of specific services; among individuals experiencing a SUD within the 12-months prior to initial assessment, 2.3% received treatment from healthcare professionals, 2% from self-help services, 1.3% to 1.6% from detox, outpatient clinics, rehabs, or inpatient facilities, and .1% to .4% from other sources. Individuals with a SUD in the 12-months prior to baseline assessment or before showed similar service utilization patterns.

DuPont (2018), in a research report, noted that only 10% of individuals with SUD undergo treatment, and, specifically, that the majority of individuals who don’t receive treatment don’t acknowledge having a substance-related problem or perceive a need for treatment. Dupont (2018) also noted that, among the small percentage of individuals who seek treatment, few actually complete treatment, with many instead dropping out of treatment early on. Thus, individuals with SUD, according to Dupont, are not likely to engage in treatment overall because of reduced perceived problem severity as well as a subsequent need to seek treatment. For those who do become involved in services, they end up disengaging early on.

In contrast to Dupont’s (2018) report, a study of low-income, female methamphetamine users (who had either used within the past 72 hours or hadn’t) in Cape Town, South Africa found that 46% of the total sample perceived a need to seek substance abuse treatment, and 92.4% of individuals who perceived a need for
substance abuse treatment wanted to actually go to treatment (Myers, Kline, Doherty, Carney, & Wechsberg, 2014). More specifically, among women who had not used within the past 72 hours, higher awareness of where to obtain treatment doubled the chance that the individual would perceive a need to seek treatment (Myers et al., 2014). Thus, not only were some women aware of the need for treatment, but they actually wanted to seek it. However, once separated by individuals who hadn’t recently used, the likelihood of perceiving a need for treatment decreased if an individual was unaware of where to find treatment. In this study, a significant amount of individuals with substance abuse challenges did desire services. For some, the likelihood of desiring services was perhaps not due to decreased problem awareness (which wasn’t examined in this study), but instead an unawareness of where to actually obtain services.

**Service utilization and insight.** Disengagement with, or underutilization of treatment may have dire consequences for individuals with SUD. In one study, the OD mortality rate for individuals engaged in treatment was over 11 times less than individuals out of treatment; types of treatments included methadone maintenance, methadone detoxification, and psychosocial treatments, with no ODs reported for individuals involved in a Therapeutic Community (Davoli et al., 2007). Thus, it is important to ascertain which factors might be related to treatment engagement depending on service type. Problem acknowledgment and motivation to seek help might be related to increased engagement with services in general or, rather/further, only engaging with specific types of services.
Peer. Peer support services are provided to people struggling with SUD by individuals who are themselves recovering from psychiatric challenges and, more relevant to this thesis, SUD. The efficacy of peer support services in helping individuals with SUD has been thought to derive from peer support providers’ personal experiences and functioning as role models (Davidson et al., 1999). Peer support is commonly divided in the literature into mutual-aid and peer recovery services (Bassuk, Hanson, Greene, Richard, & Laudet, 2016).

One form of peer support, peer recovery services, has been incorporated into the field of substance use through recovery coaching. Recovery coaches were initially incorporated into the broader field of mental health treatment for individuals with SMI (Lloyd-Evans et al., 2014). Recovery coaches are “themselves … in recovery …, [and] are uniquely qualified through their own experiential learning to assist others in similar situations” (Ashford, Meeks, Curtis, & Brown, 2018, p. 2) by helping to increase service engagement, connection to the community, and “coping and problem-solving strategies for illness self-management” (Myrick & del Vecchio, 2016, p. 198).

Recently, substance use providers have been working with peer recovery coaches in EDs and outpatient clinics (e.g., Ashford et al., 2018; Bassuk et al., 2016). The incorporation of peer recovery services into substance use treatment has been linked to positive outcomes; for example, in a review of the literature, Bassuk et al. (2016) found that most studies reported significant improvements in substance use, as well as varying recovery outcomes, such as reduced readmission rates to the hospital, for individuals involved with peer recovery services.
Mutual-aid support, on the other hand, is typically provided by 12-step groups like AA or Narcotics Anonymous (NA), and is “informal, does not require training, and is deeply rooted in bi-directional relationships of mutual support” (Bassuk et al., 2016, p. 2). These bidirectional benefits have been conceptualized as occurring due to individuals meeting with each other to discuss and “address common problems or shared concerns” (Davidson et al., 1999, p. 168), as well as by enabling people to have both structures and resources that can help them to handle these challenges (Davidson et al., 1999).

Mutual-aid support has been found as effective for people with SUD. A meta-analysis examining the effect of AA attendance on abstinence for dually diagnosed individuals found that AA exposure was positively associated with abstinence (Tonigan, Pearson, Magill, & Hagler, 2018). Further, in a literature review, most studies demonstrated the effectiveness of AA; several studies found that individuals with AA had increased abstinence rates, with two citing the benefit of active involvement in AA, like feeling supported by the group or attending more frequently (Krentzman, 2008). In terms of substance users, a literature review found that 12-step meeting attendance or involvement with 12-step activities (like obtaining a sponsor) is effective in increasing abstinence rates among substance users who primarily use stimulants (Donovan & Wells, 2007). Thus, self-help groups have been found to be effective for people struggling with alcohol and drug use, as well as people with dual diagnoses.

For the purposes of this literature review, both mutual-aid and peer recovery services will be reviewed together as part of the peer services umbrella, as both offer
similar opportunities for individuals struggling with SUD to learn from peers’ experiences and challenges, as well as obtain resources that can help enable them to handle their own challenges.

**AA/NA.** AA and NA appear to result in more benefits for those who are more involved and motivated. For example, attendance and active involvement in AA or NA-related activities (such as speaking at meetings or working the steps) predicted higher rates of abstinence over a period of one year in individuals diagnosed solely with a SUD or a SUD with another diagnosis (Bergman, Greene, Hoeppner, Slaymaker, and Kelly, 2014). In a longitudinal study examining 12-step attendance trajectories among adolescents with substance use challenges, higher levels of motivation/readiness at baseline predicted a higher likelihood of abstinence from alcohol and drugs at the 3-, 5- and 7-year follow-ups (Chi, Campbell, Sterling, & Weisner, 2011). Thus, increased motivation to address the SUD, as well as increased engagement with AA or NA, have been demonstrated to predict abstinence over time.

Additionally, individuals who attended 12-step programs at least once a week had higher motivation to address the substance-related problem than individuals who attended 12-step services less than once a week (Fiorentine, 1999). Furthermore, participants who didn’t use any drugs or alcohol in the past six months before assessment had higher motivation scores than individuals who used drugs or alcohol at least once in the six months prior to assessment. Finally, among women enrolled in a community-based outreach program, higher readiness to make changes in substance abuse problems predicted a higher likelihood of completed referrals into 12-step groups, drug detoxification services, and residential drug treatment programs (Brown,
Melchior, Panter, Slaughter, & Huba, 2000). In this case, motivation to seek help at baseline predicted completed referrals into peer recovery groups, as well as other treatment forms.

The direction of the association between motivation to seek help and increased service utilization has not been confirmed, although this relationship is consistent in the literature. However, research does appear to indicate that, if an individual attends AA, it is likely that their motivation for abstinence will increase, but if the individual has low motivation to change their behavior in the first place, they will be unlikely to utilize AA or NA services. In a literature review, Kelly, Magill, and Stout (2009) described several studies which all found that motivation for abstinence mediated the relationship between AA involvement and substance use outcomes, such as abstinence, over time among adults and adolescents. In this case, increased AA involvement is actually linked to increased motivation, which itself is related to an increased likelihood of abstinence. Laudet, Cleland, Magura, Vogel, and Knight (2004) found that social support partially mediated the inverse relationship between higher levels of participation in a 12-step group and lower substance use, indicating that social support is one potentially crucial mechanism in the effectiveness of peer recovery services. However, in another study (Laudet, 2003) both substance use treatment clients and clinicians indicated that the absence of motivation to change was one of the most salient factors preventing individuals with SUD from attending AA or NA.

**Recovery coaching.** Recovery coaching is another form of peer support that has only recently begun to be examined. However, there is evidence that peer recovery
coaches are effective in improving treatment adherence rates. For example, in a study analyzing the effectiveness of peer recovery coaches in improving post-inpatient discharge treatment adherence rates, individuals involved in recovery coaching had higher rates of engagement with treatment than individuals assigned to the treatment as usual condition (Tracy, Burton, Nich, & Rounsaville, 2011). In a qualitative study, recovery coaches motivated clients with SUD to engage in particular behaviors, like remaining engaged with treatment or preventing relapse (Jack, Oller, Kelly, Magidson, & Wakeman, 2017); specifically, one client was found to have more motivation to remain in treatment because of the coach’s hard work in connecting him to treatment. Another recovery coach relayed her experience in a situation that was similar to the client’s to prevent the client from relapsing (Jack et al., 2017). The efficacy of utilizing peer recovery services in aiding individuals with SUD is, in general, underexamined in research. Consequently, research on the effects of the utilization of peer recovery coach services on individuals’ motivation for treatment is sparse. However, the two aforementioned studies indicate that recovery coaches are helpful in increasing individuals’ motivation to remain engaged with treatment. It is unknown, however, whether contact with a peer recovery coach can spur an individual to more readily acknowledge their SUD and, consequently, decide to enter treatment in the first place.

Hope. Hope is one aspect of recovery that has been proposed as crucial in helping to aid individuals to reach goals and obtain stability (e.g., Repper & Carter, 2011; Salzer & Shear, 2002). In a systematic review, Schrank, Bird, Rudnick, and Slade (2012) reported that, out of 38 cross-sectional studies examining associations between
hope and other variables among individuals with varying psychiatric disorders, the most consistent positive associations were found between hope and social support, among other variables. They also found that hope was consistently negatively associated with familial issues as well as employment barriers (Schrank et al., 2012). Due to the social support that recovery coaches can offer clients with SUD, it would make sense if recovery coaches could help increase hope in their clients. Recovery coaches are also involved in coaching and supporting clients regarding whatever their needs are (Myrick & del Vecchio, 2016). Thus, if the client is having issues with family or employment, the recovery coach might be able to help the client problem-solve, which might further increase hope.

Research has found that interventions involving recovery coaches resulted in increased hope. In a meta-analysis examining the effects of peer interventions on outcomes concerning individuals with SMI or depression, Fuhr et al. (2014) found that, when low-quality superiority trials examining the effects of peer interventions on individuals with SMI were excluded, there was a small effect size favoring peer interventions over treatment as usual in improving hope. Furthermore, in a systematic review of peer services (including mutual support, peer-support services in which support is separate from or in addition to professional care, and peer mental health services, in which peers provide a portion or all of the care) only one study examining the effects of mutual aid measured hope and found no significant effect, but there was a small positive effect of peer support on hope, although the confidence of evidence was rated “low-grade” (Lloyd-Evans et al., 2014, p. 8). The examination of follow-up data resulted in the finding that there was a positive effect of peer support on hope,
although the effect size was small, and confidence in the evidence was low (Lloyd-Evans et al., 2014). Thus, findings seem to be inconclusive in terms of the utility of peer support (including mutual-aid) in increasing hope. Although some evidence points to the effect of peer support on hope, not all evidence fully supports this claim, as effect sizes have been small and confidence in the evidence (in terms of the study design, etc.) have been low.

Although quantitative studies have resulted in inconclusive findings, qualitative studies have found that peer support is instrumental in increasing clients’ hope. In a metasynthesis of qualitative findings concerning peer support, 20% of all articles sampled reported that clients’ hope, motivation, and social networks increased due to their utilization of peer support worker services (Walker & Bryant, 2013). Thus, although these qualitative studies examining hope and peer support in Walker and Bryant’s (2013) metasynthesis are the only qualitative studies that the author knows of, qualitative evidence seems to indicate peer coaches’ utility in increasing hope. Due to the disparate findings of quantitative and qualitative studies, it is still unclear whether peer support increases hope. However, due to the associations between hope and social support, as well as the negative relationships between hope and family issues/unemployment, it seems logical that peer coaches would increase hope.

In terms of insight and hope within the context of peer support, a systematic review reported that quantitative studies have found either no association or a negative relationship between insight and hope (Schrank et al., 2012). However, in a systematic review of qualitative studies, increased insight (into the diagnosis and the need for treatment) was found to result in increased hope because clients felt they
were given “tools to manage their symptoms” (Schrank et al., 2012, p. 556). Thus, there is also a disparity between findings of qualitative and quantitative studies in relation to insight and hope within the peer support context.

**Professional.** Due to the potential effects of specific services on insight, individuals might experience increased insight by using professional services, such as rehabilitation or inpatient treatment, harm-reduction services, or Emergency Department services. Prior research has demonstrated that insight is associated with the use of professional services, such as harm-reduction, rehabilitation, and psychotherapy services. However, research on the effect of using professional services on insight is sparse.

**Rehab/inpatient treatment.** In terms of insight and rehabilitation centers or inpatient treatment, there is little extant research. One study, however, examined motivation for abstinence, among other variables, in young adults receiving treatment at a residential program (Kelly, Urbanoski, Hoeppner, & Slaymaker, 2012). The authors found that motivation levels were high at baseline and increased during treatment as assessed at three-month discharge. Although this study did find that motivation increased over time, motivation levels were already high at baseline and, consequently, motivation might only increase among those who demonstrate high levels initially. Further, this is the only study found examining insight and the use of rehabilitation services, and, therefore, no determination can be made as to individuals’ motivation to engage with these kinds of services in general.

**Harm reduction/MAT.** Harm-reduction approaches, such as medication-assisted treatment (MAT), have been demonstrated as effective in aiding individuals to
recover from SUD (Pierce et al., 2015). Although, to the author’s knowledge, there is little research assessing insight among individuals who have previously used, or who are using, MAT or other harm-reduction services, Roozen and van de Wetering (2007) emphasized that harm reduction approaches, specifically involving the use of medications such as naltrexone, buprenorphine, and methadone, result in the highest treatment retention rates (treatment retention implying motivation for treatment). Since MAT services have been demonstrated to reduce the rate of OD and mortality among substance users (Saxon, Hser, Woody, & Ling, 2013), future research would benefit from an assessment of individuals’ motivation levels to start MAT services or, additionally, to engage with MAT services after prior utilization.

**Outpatient (psychotherapy/outpatient group counseling).** Studies examining insight and the utilization of outpatient services (such as psychotherapy and outpatient group counseling) are, similarly, sparse in prior research. In the only study that the author could locate, among substance abusers utilizing an outpatient drug counseling center’s services, taking action steps scores significantly increased over time from baseline to 6 weeks post-treatment (Duffett and Ward, 2015). Among the intent-to-treat analysis group, ambivalence related to the substance-use problem decreased over time, taking actions steps increased, and there were no changes in problem acknowledgment levels. Among participants who provided data at baseline and 10 weeks post-treatment, problem recognition scores decreased over time, taking action steps scores increased, and ambivalence levels did not change, indicating that, over time, participants likely improved (thus reflected in reduced problem recognition scores), and motivation to be active in their recovery increased with time. There are
no further studies the author is aware of that have examined insight and outpatient
group counseling, and none that assess insight and the use of psychotherapy. Future
research would benefit from assessing these relationships, as the utilization of specific
services in general may be related to increased taking action steps scores as a result of
enrollment in treatment in general or, conversely, may only be related to using
specific kinds of services.

Emergency department. Although there are few studies examining how
experiences in the ED affect baseline insight, several studies have examined baseline
levels of insight during initial presentation to an ED, and have found that insight
levels appear to be consistently low. Individuals with SUD present to the ED at high
rates, with ED visits in which substance abuse or dependence was present, as
categorized by the survey using DSM-IV terminology, accounting for 6.6% of all ED
visits in 2015 (Rui & Kang, 2015). In a study examining factors predictive of clinical
insight among individuals with psychiatric disorders presenting to the ED, patients
presenting to the ED who had substance abuse problems were four times more likely
to have lower insight compared to individuals presenting to the ED for a medical
problem (Agyapong, 2016). In a study examining predictors of substance use after
leaving the ED and variables related to readiness to change, Myers, Van der
Westhuizen, Naledi, Stein, and Sorsdahl (2016) found that individuals who presented
with an injury related to substance use were more likely to have higher recognition
but lower taking action steps scores than individuals who did not have an injury, and
individuals with substance use problems overall had low levels of problem
acknowledgment and motivation to take steps at baseline. However, Myers et al.
(2016) noted that participants in this study weren’t presenting to the ED for help with their substance use, but rather for health care. Overall, then, it seems that individuals with substance abuse problems presenting to the ED are not likely overall to have high levels of insight. However, since the two aforementioned studies did not explicitly assess insight levels of patients who did present to the ED with a substance-related complaint, research would benefit from examining insight levels of individuals who are seeking help from the ED for a substance-related complaint, particularly considering the high rates of ED usage in this population.

**Substance abuse and service satisfaction.** One important factor in substance abuse treatment is treatment satisfaction. O’Brien et al. (2009) emphasize that, although service utilization is commonly used as a proxy for treatment engagement, it is possible that individuals may not have positive viewpoints regarding their treatment despite high service utilization rates. Thus, it is important to ascertain not only whether insight is impacted by, or impacts, treatment engagement, but also whether service satisfaction is related to insight.

**Satisfaction with professional services and insight.** Service satisfaction has been indirectly assessed in relation to professional services. For example, although not directly related to treatment satisfaction, Stevens, Radcliffe, Sanders, and Hunt (2008) found that participants primarily cited issues with treatment, such as a disparity between what the individual wants and is receiving, as well as extensive waiting times, as motivators to leave treatment. Thus, perceived problems actually motivated individuals to discontinue treatment, even if they may have wanted it. Similarly, another study found that people's negative perceptions of treatment (for example,
having to wait too long to enter treatment and issues associated with missed appointments) contributed to participants not reentering treatment or seeking treatment for the first time (Notley, Maskrey, & Holland, 2012). Thus, individuals’ prior experiences, or perceptions of treatment before entering for the first time, factored into low levels of motivation to seek help for the substance-related problem, even if help was desired. Future research would benefit from confirming these findings, as these are the only two studies the author knows of that assess service satisfaction and one facet of insight.

Satisfaction with peer services and insight. Research on the broader topic of the efficacy of peer recovery coaches in aiding individuals with SUD remains sparse. There is only one study the author is aware of which assessed levels of satisfaction with peer recovery services and one potential facet of insight, which is motivation to utilize services, as reflected by service utilization rates. In this study assessing recovery outcomes of veterans involved in veteran peer support groups, overall satisfaction with peer support groups was moderately and significantly positively correlated with the number of groups attended in the previous month as well as the length of time utilizing peer support services (Barber, Rosenheck, Armstrong, & Resnick, 2008). Thus, in this study, satisfaction with peer recovery services was related to overall service utilization. Since this is the only study found, research would benefit from assessing satisfaction and insight levels among individuals utilizing peer recovery services.

Emergency department satisfaction and insight. An additional area of research regarding service satisfaction concerns treatment in the ED. ED services are
particularly relevant in consideration of substance abuse, particularly opioid abuse, due to the high rates of individuals who are seen in EDs due to ODs (Samuels et al., 2018). In a study examining the effects of health promotion advocates on connecting alcohol and substance abusers in the ED to post-ED services (Bernstein, Bernstein, & Levenson, 1997), more than half of the patients cited their experiences with health promotion advocates as responsible for their future reduced alcohol and substance use. Thus, health promotion advocates in the ED were largely perceived as helpful by clients and crucial in their reduction of harmful substance use in the future. This indicates that interventions in the ED, which clients perceive as useful and helpful, have the potential to greatly influence substance users’ outcomes.

Although research examining any relationship between ED service satisfaction and insight is minimal, one study did find that satisfaction was positively related to motivation. In this study, which involved examining the implementation of an electronic referral system in the ED, Boudreaux et al. (2009) found that all 85 patients (of which 48 were identified as risky substance users), had high levels of satisfaction with the system and reported high levels of motivation as a result of the intervention. Although this is the only study found that examined satisfaction levels and insight, it might be the case that ED satisfaction is related to motivation to take action steps due to being satisfied with treatment in general. Future research would benefit from examining this relationship, as the ED offers a unique opportunity to intervene on many substance abusers’ outcomes.

O’Brien et al. (2009) suggest that, although service utilization is an important factor in substance abuse patients’ treatment, service engagement is a “complex
phenomenon … that include[s] acceptance of a need for help, the formation of a therapeutic alliance …, satisfaction with the help already received and a mutual acceptance and working towards shared goals” (p. 559). Thus, research would benefit from assessing not only service utilization rates but service satisfaction as well, in order to adequately assess how well clients’ needs are being met and whether meeting needs is an important factor in problem acknowledgment and subsequent motivation to seek help.

An additional area of research involves the examination of how prior experiences in treatment affect future service utilization. In a study examining differences in client satisfaction between pregnant and postpartum women with substance abuse challenges who were involved with peer counselors and a comparison group, clients who had worse treatment experiences before entering treatment were more likely to have higher levels of treatment satisfaction (Sanders, Trinh, Sherman, & Banks, 1998). Additionally, those with higher levels of treatment satisfaction were more likely to have stayed in treatment longer, as well as used more services within the past month. This is the only study the author is aware of that has assessed prior service satisfaction levels, and how they affect future perceptions of services. Since some substance users have previously used services, future research would benefit from an examination of whether prior treatment satisfaction history bears on future motivation to seek help, as substance abusers typically follow a trajectory of numerous relapses and, hypothetically, attempts to seek help.
Reconceptualization

Currently, there is insufficient research on clinical insight in people diagnosed with varying psychiatric disorders. Additionally, many studied relationships between clinical insight and other variables are inconsistent, such as the relationship between clinical insight and treatment engagement, and symptom severity in schizophrenia. However, the positive relationship between insight and depression in schizophrenia has been demonstrated as consistent across studies, although individuals who are involved with peers and find a community generally report less negative effects of insight, such as decreased stigmatization. In consideration of the literature reviewed, it appears that the most reliable finding points to the fact that clinical insight can have potentially detrimental effects if the individual has internalized stigma attached to receiving a psychiatric diagnosis, and social support can help mitigate these detrimental effects.

In terms of insight among people with SUD, there are some psychosocial and structural findings which appear to be consistent. In terms of psychosocial findings, notably, that insight is not consistently related to addiction severity, increased addiction severity is consistently related to lower SQOL, and perceived stigma is consistently associated with distressing psychological states (such as depression and lower self-esteem), similar to those diagnosed with other psychiatric disorders. Further, social support has also been found to positively impact individuals with SUD. In terms of structural variables, consistent findings include the effect of particular services, perceptions of services, and perceived ability to access services on motivation to seek help. Due to these consistent findings, insight in SUD and,
concurrently, OUD, can be conceptualized as affected by structural and social conditions, as well as conditions that might limit potential meaning-making and personal development.

**Reconceptualization of insight.** This conclusion proposes a person-centered and recovery-oriented reconceptualization of insight in SUD. Person-centered perspectives on care emphasize attentiveness to individual needs, freedom of choice, and a sensitivity to unique characteristics of individuals. The conception of recovery used in this thesis emphasizes the individual’s determination of what recovery means to them, as according to their unique needs and goals. This reconceptualization is both person-centered and recovery-oriented by emphasizing the unique structural, social, and personal circumstances that individuals with OUD might face, as well as their importance in the individual’s potential for personal growth, problem acknowledgment, and motivation to seek help. This person-centered reconceptualization aims to, therefore, broaden the scope of factors that are understood to impact service-seeking and problem acknowledgment by describing their potential influence on individuals’ perceptions of a fulfilling future. The conclusion also proposes the initial facilitation of an understanding of individual’s goals for personal growth, as well as a meaningful, fulfilling life and recovery, rather than an immediate and narrow focus on insight as defined in the previous literature and this thesis.

In order to understand these factors and the ways in which they might influence a person-centered, recovery-oriented understanding of insight, I present a synthesis of previous research that highlights the ways in which research does not adequately
address the structural, social, and personal circumstances of people with OUD, and outlines how we might understand insight in OUD as related to these numerous influential aspects of recovery. Structural aspects are first reviewed, and social support is reviewed next. The third section details the potential lack of opportunities to derive meaning from their experiences and pursue personal development. Finally, I will offer a detailed explication of a person-centered, recovery-oriented reconceptualization of insight in SUD and OUD. This reconceptualization offers a solution for how clinicians and researchers might address these aspects in a way that can help people with OUD address their substance use problem. The solution entails an attendance to these aspects in research and by clinicians, as well as an increased understanding in the research literature, and enhancement by clinicians, of people’s overall well-being, goals for recovery, and personal growth.

**Structural concerns.** Individuals with SUD, and OUD specifically, face issues in the society that they live in that are likely outside of the scope of mental health interventions. These particular societal and structural issues that people with OUD face might contribute to a lack of insight if individuals don’t feel that future service providers will understand their unique life circumstances and challenges. Insight might also additionally be prevented from developing if individuals don’t feel that service providers will listen to and incorporate their perspectives on the care they are currently receiving, or the type of care that they would like to receive in the future. For example, individuals with SUD generally have a low SQOL, which includes issues such as problems gaining employment, having a low standard of living, and feeling unsafe in their community. Therefore, they commonly experience unique
demands and face problems that might not easily be addressed by traditional mental health care systems or treatments. If individuals don’t believe that potential service providers will work to at least understand, and ultimately address and help the individual rectify, these issues, then individuals might not feel motivated to seek their assistance.

Further, individuals with SUD have been found to have an increased perceived need to seek services if they know where to obtain these services. If they don’t know where to obtain services, or even know how to ascertain what kinds of services they want, they might not feel motivated to address the problem or acknowledge it in the first place, because they might not have hope that whichever service they seek will be useful, or whichever service they want will be available. Additionally, low service satisfaction has been found to prompt individuals to drop out of treatment, and high satisfaction increases engagement with services over time. Also, considering the low service utilization rates of individuals with SUD, it might be the case that people aren’t using services because they have had previous experiences that were negative. Although one previously mentioned study did find that worse prior experiences led to more motivation, it might be the case that people might be more motivated only if they perceive the service they are currently receiving or are supposed to receive as what they want, and therefore potentially useful and motivating.

**Social support.** Social support has been found to reduce experiences of perceived stigma, which can impact problem acknowledgment by reducing perceived negative repercussions attached to disclosing or appearing to have a psychiatric diagnosis. Further, lack of community connection might factor into motivational difficulties.
Additionally, perceived stigma might facilitate further social disconnection if there are concerns about others finding out about their substance-related challenges, and there are limited opportunities for the individual to engage in positive, healthy, and supportive interactions with others that might reduce perceptions of stigmatization.

As mentioned, people with SUD and OUD generally have a low SQOL, which includes feeling disconnected from the community. Social support has been demonstrated to positively affect people with SUD in terms of increasing their motivation to remain engaged with treatment and reducing substance use over time. If their SQOL is low, however, then there are likely limited opportunities for the individual with OUD to derive social support that they find helpful and valuable. They also might be experiencing social interactions that aren’t satisfying or don’t nurture self-development and striving towards fulfilling goals. Thus, the lack of connection to the community and to peers, and therefore the opportunity to be involved in relationships that encourage self-development and the pursuit of recovery, likely affects individuals’ insight in the sense that the opportunity to help increase their motivation to seek services that will aid their recovery isn’t present.

Additionally, having a low standard of living is one aspect of a low SQOL. It thus might be the case that, due to having a low standard of living, individuals might have a difficult time finding opportunities to spend time with others due to limited financial resources, as well as a lack of safety. All of these factors might impact the motivation that someone has to attempt to live a different, substance-free or harm-reduction focused life in the future, because this future might seem bleak due to the perceived lack of opportunities to change their circumstances.
Additionally, as mentioned in this review, people with SUD can experience stigma, which can impact insight in the sense that people might feel afraid to acknowledge a diagnosis of SUD or OUD because of the potential repercussions it could bring. In addition, people might anticipate potential negative effects of acknowledging the diagnosis on their self-perceptions. Social support can help reduce perceived stigma, but if people feel stigmatized by their family, peer group, or broader community then they might not seek social support. This lack of social support could further impact the drive to acknowledge and address their OUD by seeking help.

**Meaning-making and personal development.** People with SUD and OUD are likely limited in regard to having opportunities to discuss goals for the future and develop personally and, subsequently, having the opportunity to increase self-esteem and self-efficacy by reaching these goals. This might reduce motivation to seek help if people don’t feel that they have anything to look forward to in recovery, or anything to strive towards in terms of personal fulfillment and growth. This limited opportunity to envision a different, and better, future likely also impacts the actual opportunity to grow and derive meaning from their experiences using substances or recovering from substance-related challenges.

Individuals’ perceptions of having meaning in their lives are likely affected by having a low SQOL. If people are not able or encouraged by peers, the community, or service providers to develop their own understandings of what they want out of life, then they might not see the point of seeking treatment, because they might not believe that there is a possibility of a more fulfilling life in the future. Further, if individuals
believe they will return to the same kind of life as before, which might have been depressing or unfulfilling, they might not see purpose in seeking treatment or even acknowledging the substance-related issues. This is particularly relevant to research that points to substance use as a coping mechanism (e.g., Gold, Stathopoulou, & Otto, 2019; Hogarth, Martin, & Seedat, 2019), especially in relation to the need to cope with an unfulfilling or distressing life (e.g., Heggeness, Lechner, & Ciesla, 2019). Additionally, if SQOL is low, then people might not feel hopeful, which could further impact the drive to determine what a meaningful life would look like, thus also negatively impacting the view that acknowledging the problem or seeking help will lead to anything useful or beneficial in the future. Finally, people with SUD and OUD might not have high self-esteem if they lack social support, which might result in limited motivation to develop the self and achieve goals. Perceived stigma also might lead to low self-esteem, which can further impact SQOL, hope, and the drive to identify personally salient and important goals.

*Person-centered and recovery-oriented reconceptualization of insight.* Individuals with SUD and OUD have unique challenges that clinicians and researchers need to attend to. Essentially, clinicians and researchers need to better understand their unique circumstances beyond problem acknowledgment and motivation to seek help, because individuals with OUD are likely dealing with challenges that factor into and affect this conception of insight. A more person-centered and recovery-oriented insight enables a broader understanding of individuals’ unique challenges, standpoints, and desires in life.
Clinicians and researchers, therefore, should work to understand the issues previously outlined that exist outside of the mental health system (structural issues), to gain a better understanding of the barriers that exist in seeking treatment and living a fulfilling life. By understanding their unique demands and circumstances, clinicians and researchers can better address what might be impacting the acknowledgment of a substance-related issue that needs to be addressed. They also need to pay attention to perceptions of services, as these perceptions can impact motivation to initiate help-seeking behavior, as well as influence insight over time while in treatment. Additionally, the quality and amount of social support of people with SUD and OUD needs to be addressed in terms of helping them to build connections to others and the world at large. Relatedly, perceived stigma and social support are potentially mutually interactive, and both have the potential to impact insight. Finally, low levels of self-esteem, SQOL, and hope might all affect the drive to identify goals, which can impact insight because the individual dealing with substance-related and general life challenges might have limited opportunities or motivation to explore what their life would look like in recovery. Their opportunities to grow personally in recovery, and thus feel motivated to pursue recovery due to resulting personal benefits, are also likely limited.

In consideration of these unique challenges, the field would benefit from a person-centered and recovery-oriented reconceptualization of insight. The reconceptualization involves expanding the conception of insight beyond problem acknowledgment and the motivation to seek treatment to an understanding that incorporates broader structural, social, and personal development aspects. This
person-centered and recovery-oriented reconceptualization views insight as not primarily or solely dependent on neurobiology or the severity of addiction, but rather subject to the broader demands and challenges that people face. Research would benefit from adopting this conception, as it has promise in ascertaining the potential reasons why people might not feel motivated to accept that a problem exists or feel motivated to pursue services that will address their OUD. This reconceptualization of insight also implicates the importance of understanding what the person with OUD wants out of life in terms of future goals and plans for fulfillment, as well as how they think they might reach these goals and plans, and how this might impact insight as defined in the previous literature. If people are not able to develop their own understandings of what they want out of life then they might not have high levels of insight (as aforementioned), because they might not believe that they will be fulfilled, or able to live a fulfilling live, after deciding to address the problem.

In addition to understanding insight as affected by these recovery aspects, as well as understanding how these aspects affect personal growth, beliefs in the possibility of a fulfilling future, and subsequent motivation to address the acknowledged problem, clinicians would perhaps be more effective in first helping the individual to facilitate these understandings rather than immediately focusing on insight as defined in prior literature. Individuals with OUD would likely benefit from focusing on the potential meaning that they can derive from their experiences using substances, goals for the future, better connection to their community, and ways to consider life without substances or problematic drug behaviors. A focus on helping the individual to acknowledge their problem and thus develop motivation to seek help could maybe
come later as a result of first, and primarily, exploring what life would be like in recovery. An identification of how the individual wants their life to proceed, and what the benefits of entering recovery are, could help to develop hope to pursue services, as the pursuit of services can help the individual to reach their desired goals. As people begin to develop hope for the future and start reaching towards accomplishing goals, they might experience less perceived stigma due to increased perceptions of self-efficacy and self-esteem. Due to this, the person thereafter might be better able to decide to address the problem because they will not only experience less consequences due to internalized stigma, but also potentially benefit from treatment or services to be received, because these services will help them to further reach their desired goals and life plan. This exploration of personal meaning or other desired goals can occur even if the individual is still using or relapses after abstinence. This ability to pursue personally relevant and valued goals can help to maintain the motivation a person has to seek services because they will consistently be able to strive towards reaching goals regardless of potential setbacks, and therefore won’t be demoralized by feeling as if they have failed if they relapse or fail to achieve abstinence. This consistent striving toward reaching personal goals and deriving meaning can also help to build perceptions of personal growth in recovery, which can further motivate the individual to remain in recovery because they will feel as if they are progressing in a purposeful manner. This can be viewed in relation to PTG, which, as mentioned in the broader review, has been associated with more willingness to seek help, as well as higher levels of coping, support and guidance seeking, and seeking of alternative rewards. Therefore, reaching goals in recovery can potentially
help further motivate the individual to continue reaching additional goals (including abstinence, if the individual desires it), by increasing available resources for recovery, building a sense of purpose and meaning in life, as well as by helping the individual to cope with life demands and circumstances without abusing substances in a problematic manner as frequently or, potentially, at all.

**Conclusion**

Findings on clinical insight in people with varying psychiatric disorders, and its relationships with variables like treatment engagement, symptoms, and SQOL, are inconclusive. Prior research consistently indicates, however, that clinical insight can negatively impact individuals by increasing internalized stigma and, subsequently, hopelessness and demoralization. Findings regarding insight in SUD and OUD are also inconsistent, such as the relationship between insight and addiction severity, as well as insufficiently addressed by research, such as levels of, and associations with, insight after an OD. However, research consistently indicates that people with SUD and OUD experience unique psychosocial and structural circumstances and challenges that can impact insight. The person-centered and recovery-oriented reconceptualization of insight presented in this thesis highlights these unique circumstances and challenges, and their potential impact on insight, personal growth, and life fulfillment. The reconceptualization also argues for clinicians to focus initially, and primarily, on understanding individuals’ goals for growth, as well as a meaningful, fulfilling life and recovery, rather than immediately focusing on the narrow conception of insight as defined in prior research.
Directions for Future Research

Future research should provide further support for the positive relationship between addiction severity and problem recognition, and the lack of a relationship between addiction severity and motivation for treatment. This research could be conducted by using qualitative research methods in order to further support the notion that people might acknowledge that there is an issue, but not have motivation to seek services due to potential barriers or a lack of knowledge regarding where to seek services that they want. Qualitative methods could also help to better understand and detail potentially unique and circumstantial barriers that people might perceive or experience that prevent them from seeking treatment.

Relatedly, research should directly examine how service satisfaction impacts insight, and whether the use of particular types of services, or engagement with services in general, affects insight. For example, as outlined in the broader review, harm-reduction approaches have particularly high treatment retention rates. Research could examine, for example, whether people experience greater satisfaction with harm-reduction approaches and, accordingly, are more engaged with treatment due to increased motivation.

Research should also provide further support in terms of the absence of insight after an OD, and, relatedly, should explore insight levels after being seen in an ED for an OD. Qualitative research could potentially offer a more in-depth understanding of why people might perceive future ODs as unlikely and why they don’t feel the need to seek help. This could be examined within the context of the ED, as service providers themselves, or the services that they provide, might have an effect on
perceived stigma and hope, and a subsequent effect on insight. Relatedly, research needs to provide further support for the relationship between higher perceived stigma and higher problem awareness, as well as explore the relationship between perceived stigma and motivation to seek help. This elucidation of the relationship between perceived stigma and insight might be able to clarify the potential impact of perceived stigma on insight in the ED context.

In relation to the person-centered and recovery-oriented reconceptualization of insight in SUD, research would benefit from examining the impact of recovery coaches in helping individuals with OUD. As outlined in the broader literature review, recovery coaches have demonstrated promise in helping individuals in their SUD recovery and in increasing motivation to remain engaged with services. Research could further examine whether engagement with recovery coaches results in increased insight and subsequent service utilization and satisfaction, as compared to other service types, due to their hypothesized effects on hope, perceived stigma (due to the social support they offer), and SQOL (by facilitating connection to the community, listening to the individual’s needs, and helping them reach goals that will facilitate a satisfying and fulfilling life.) Additionally, research should further examine the phenomenon of PTG in people with SUD and OUD, as findings concerning this phenomenon in people with SUD need to be replicated. If PTG does reliably occur among people with OUD (perhaps only under certain conditions), then research could examine the impact of recovery coaches on the phenomenon, as recovery coaches might be able to help facilitate PTG by discussing the client’s
experiences, as well as the recovery coach’s own experiences, with substances, recovery, and their process in building a new life.

**Implications**

The person-centered and recovery-oriented reconceptualization presented in this thesis has applied value in terms of implementing this new conceptualization for researchers, clinicians, and people with SUD and OUD themselves. This reconceptualization can be utilized by researchers to better ascertain the factors that impact insight, as well as factors that affect perceptions of a fulfilling future and subsequent motivation to seek services, which can ultimately help to address the low service utilization rates and high prevalence rate of OUD. This reconceptualization could also be used in clinical practice, as outlined above, by focusing initially on helping people to develop plans and goals for the future, rather than immediately focusing on insight as defined in prior literature. This person-centered and recovery-oriented insight, as used in clinical practice, might better enable people with OUD to feel motivated to seek services by helping them to set and reach goals, as well as grow and develop personally and, subsequently, develop hope for the future. This use in clinical practice has implications for reducing the prevalence rates of OUD and associated challenges.
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