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Spanish adaptation of the Scale to Assess Unawareness of Mental Disorder (SUMD)

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Introduction. The aim of this paper is to examine the reliability and external validity of the Spanish adaptation of the Scale to Assess Unawareness of Mental Disorder (SUMD).

Method. A translation-backtranslation of the original scale was elaborated, and a panel of professionals participated to assess conceptual equivalence and naturality. The scale consists of 3 general items: awareness of mental disorder, awareness of the effects of medication and awareness of the social consequences of the disorder; and of 17 items related to specific symptoms, which make up two subscales: awareness and attribution. Thirty-two patients diagnosed of schizophrenic or schizoaffective disorder following DSM-IV criteria were evaluated. The evaluations were performed using interviews with an observer. Intraclass Correlation Coefficient (ICC) was calculated for the reliability analysis and the Spearman correlation coefficient between the SUMD scores and one independent score of global insight for external validity.

Results. The ICC were all over 0.70. Convergent validity with the independent global measurement of insight was found for the general items of awareness of mental disorder and awareness of the effects of medication, and for the subscale on awareness of symptoms. The awareness of the social consequences of the disorder and the subscale on attribution did not correlate significantly with the global measurement of awareness (insight). These results are consistent with the hypothesis that awareness (insight) is a multidimensional phenomenon.

Conclusion. The Spanish adaptation of the SUMD scale is conceptually equivalent and displays a similar reliability and external validity as the original version.

Key words:
Awareness. Mental disorder. Insight. Schizophrenia.

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Adaptación al español de la escala de valoración de la no conciencia de trastorno mental (SUMD)

Introducción. El objetivo del trabajo es examinar la fiabilidad y la validez externa de la versión en español de la escala de valoración de la no conciencia de enfermedad mental (SUMD).

Metodología. Se utilizó un método de traducción-retrotraducción y la participación de un panel de profesionales para valorar equivalencia conceptual y naturalidad. La escala se compone de 3 ítems generales: conciencia de trastorno mental, conciencia de los efectos de la medicación y conciencia de las consecuencias sociales del trastorno, y de 17 ítems destinados a síntomas específicos que conforman dos subescalas: conciencia y atribución. Se valoraron 32 pacientes con trastorno esquizofrénico o esquizoafectivo, según criterios DSM-IV. Las evaluaciones fueron realizadas mediante el sistema de entrevista con observador. Se calculó la fiabilidad a través del coeficiente de correlación intraclase (CCI) y la validez externa mediante el coeficiente de correlación de Spearman entre las puntuaciones de la escala y una medida independiente de conciencia global de trastorno.

Resultados. El CCI fue siempre superior a 0,70. Los ítems generales conciencia de trastorno y conciencia de los efectos de la medicación y la subescala conciencia de los síntomas se correlacionaron significativamente con la medida global de conciencia. Contrariamente, el ítem general conciencia de las consecuencias sociales del trastorno y la subescala de atribución no se correlacionaron significativamente, lo que apoyaría la idea de que la conciencia de trastorno es un fenómeno multidimensional.

Conclusiones. La versión al español de la escala SUMD es conceptualmente equivalente y presenta una fiabilidad y validez similares a la original.

Palabras clave:
Conciencia. Trastorno mental. Insight. Esquizofrenia.

INTRODUCTION

Lack of awareness of the disorder itself (or lack of insight) is a frequent phenomenon in patients affected by a

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psychotic disorder. In the WHO international pilot study on schizophrenia[1], it was observed that 97 % of the patients had awareness deficit. After, similar results were found in chronic hospitalized schizophrenic patients[2]. In more recent studies with non-institutionalized psychotic patients, it was found that 57 % of patients with schizophrenia had moderate-severe deficit of disease awareness, 32 % manifested an important alteration regarding the social consequences of their disease, and 22 % denied the need or benefit of the medication. Furthermore, awareness deficit is more prevalent and severe in patient with schizophrenia than in patients with another type of psychotic disorder[3]. However, other works have not found differences between schizophrenic and bipolar patients[4,5].

In psychoses, awareness of disease refers to having an awareness of suffering a mental disorder, of needing treatment, and social awareness of the disorder as well as the capacity to form a new concept about the symptoms as pathological or to make an adequate attribution of them[6,7]. Therefore, the current ideas consider awareness more as a continuous and multidimensional phenomenon than as dichotomic of the type «present or absent». In addition, this is a complex construct that is not exempt from ambiguity that generates important theoretical controversies[8]. From an empirical point of view, different scales have been developed in order to capture this phenomenon. The most frequently used scales have shown high levels of correlation and therefore have concurrent validity, suggesting that it is a phenomenon which, although partially, may be measured and answered[9,10].

Scarce awareness of disorder has been related with worse therapeutic compliance[11-3] and, inconsistently, with inadequate use of the care resources[14-15]. It has also been associated to involuntary hospitalization[16,17], greater distortion in the subjective perception of quality of life[18,19], were social functioning[20] and, globally, worse course[21,13,17,12,22]. The relationship between the lack of awareness with severity of psychopathological symptoms of psychosis is not clear although globally in the studies are consistent in finding correlations in the range of weak to moderate between global scores of insight and scores of psychopathological severity[23]. In regards to the association with subtypes of symptoms, there seems to be a small negative relationship between insight and symptoms, this being positive as well as negative and global[24]. On the other hand, although the relationship between risk of suicide and awareness of disorder is complex, there seems to be an association between intact awareness of disorder and greater risk of suicide in some patients[25-27].

Different hypotheses have been proposed to explain the lack of awareness in psychosis. The clinical hypothesis contemplates awareness deficit as one more symptom of psychosis, related with the nature itself of the disorder, whether as a primary independent symptoms[28], or as a specific direct manifestation of the positive, negative or disorganized symptoms[29]. The motivational hypothesis understands lack of awareness of the disorder or denial of the disease as a psychological defense or coping strategy aimed at preserving an integrated perception of the subject[21,30,31]. The attributional hypothesis understands lack of awareness from the basic need that the human being has to interpret the perceptual world and provide it with an explanation that makes it understandable[32]. Finally, the neuropsychological hypothesis states that the lack of awareness would be the direct result of a deficit in the systems that record the conscious perception and that would be related with the brain deterioration produced in schizophrenia. In this sense, it would be related with anosognosia[7].

Due to all of the above, the study of the lack of awareness of disorder in psychosis has become a goal of legitimate research. However, the study of the awareness has also led us to propose using the approach of subjectivity in psychosis. Although psychosis essentially disorganizes mental functioning, recognizing the different levels of awareness of disorder brings us a little closer during the clinical work to that which is essentially human. In the between wars Europe, under the domain of eugenesic thinking, Aubrey Lewis proposed the study of awareness of disorder in psychosis as a way of rescuing the humanity of the mental patients[6,33]. At present, in the period of the democratic principles and recognition of the rights of the patients, the study of awareness of disorder in psychosis provides an opportunity to advance in the knowledge of the mechanisms of awareness and of human subjectivity.

As has already been mentioned, several scales have been developed in order to capture and deal with this phenomenon. Among these, the scale to assess unawareness of mental disorder, SUMD[12,34], has been shown to be valid and reliable, it being widely accepted and used as a multidimensional measure of awareness of disorder. Thus, since the SUMD has been developed, it not only has been validated and studied in a large group of clinical samples but has been translated to at least 11 languages by non-Anglo Saxon country investigators. In our country, although the scale has been translated in several publications of compilation of scales and is being used in clinical and research contexts, up to now no study on the adaptation of the version into Spanish of this scale has been made available.

The SUMD is a standardized scale that is scored on the basis of a direct semistructured interview with the patient. The scale is made up of three general items to assess awareness of having a mental disorder, awareness of the effect of the medication and awareness of the social consequences of the mental disorder and of 17 items aimed at specific symptoms. Awareness and attribution that each patient makes of him/herself are evaluated in each one of these 17 items-symptoms. Thus, two subscales are made up: that of awareness of the symptoms which is the mean of the sums of the scores according to the number of items scored and that of attribution of the symptoms which is the mean of

the scores of the symptoms that could be assessed because the patient is aware of them. In addition to considering different dimensions and distinguishing between awareness and attribution of the symptoms, SUMD also makes it possible to make a differentiated assessment between present and past awareness of each one of them in its original form.

The scale allows for a total of five scores, one for each one of the three general items, a fourth one for the awareness subscale and a fifth one for the attribution subscale. All the scores, both the general items and the symptom subscales, are located in a range of 1 to 5. The highest scores indicate a more incorrect level of awareness of disorder or of attribution (worse awareness).

While the three general items must always be assessed, awareness of the 17 items that refer to the symptoms can only be assessed if they are clearly present. Then attribution is assessed only if the patient has shown total or partial awareness of the symptom, that is, if the score for awareness of the symptom is between 1 and 3. The symptoms for which no awareness has been expressed cannot be assessed in their attribution. Thus, the attribution subscale is partially dependent on the awareness subscale.

There is a brief SUMD scale by the same authors in which there are only three general items and six item-symptoms in which only awareness and not attribution is evaluated[3]. The evaluation of the items is made on a scale of 0 to 3, the highest scores corresponding to non-awareness of the disorder. It has been assumed that the brief scale is valid and reliable as is the original one. Although its simplicity facilitates the use of the scale, information is lost, especially in relationship to negative symptoms and the evaluation of the attribution of the symptoms is also lost. On the other hand, a different score range is used. All of this hinders the comparison between the studies that are using these scales.

The purpose of this study is to evaluate the psychometric properties of the adaptation to Spanish of the SUMD scale. As has been mentioned above, the SUMD scale was designed to evaluate non-awareness of mental disorder and relationship to a present episode and also in relationship to a past episode of the disorder. In our work, we have only made an evaluation of the characteristics of the scale for the symptoms present.

METHODOLOGY

The method used was translation-back translation, so that the training manual and scale provided by the author (X. F. Amador) which had already been translated into Spanish, were backtranslated again into English by one of the investigators (S. Cuppa) who was bilingual, and then retranslated to Spanish together with the participation of a panel of professionals to evaluate conceptual equivalency and naturality. The Spanish version from this process can be obtained on request to the author. A summary of the scale is included in appendix 1.

In the first phase, a training process was conducted in which interviews were made to 15 patients and their literal answers given by the patience to each observer were collected. Based on these, the investigators agreed on the wording of the questions and the value given to the answers of the patients.

After, 32 patients, diagnosed of schizophrenic or schizoaffective disorder in accordance with DSM IV criteria, who were admitted to partial hospitalization regime and stabilized on the psychopathological level, were evaluated. The group was made up of 28 men and 4 women whose mean age was 36.3 years (SD = 7.1).

The clinical symptoms were evaluated by the reference psychiatrist using the PANSS scale in an independent way and after the administration of the SUMD during the same week. The interviews to evaluate non-awareness of mental disorder were conducted by the investigators (two psychiatrists and two psychologists) using the system of interview with observer, so that each interview obtained to independent evaluations. Following the method proposed by the original authors, only those symptoms included in the subscale of symptoms that were clearly presented were evaluated, the evaluations of the PANSS scale, direct observation and the solid references of the healthcare staff in the family being used as reference.

The analysis of the data was conducted using the SPS statistical program version 12.5. The intraclass correlation coefficients (ICC) were calculated for the reliability study while external validity was calculated using Spearman's non-parametric correlation.

RESULTS

General items

The mean scores for the three general items were 2.4 (SD = 1.38), 2.09 (SD = 1.17) and 2.03 (SD = 1.40), respectively.

The Intraclass Correlation Coefficient (ICC) for independent scores obtained per interview was calculated. The ICC for item 1 was 0.85, for item 2 was 0.87 and for item 3 was 0.91.

Items of the subscales

Items 5, 14, 15, 16, 17 and 20, which correspond to the symptoms of delusion, affective blunting, avolition-apathy, anhedonia-asociality, reduced attention and poor social rapport, respectively, are present in more than 50% of the patients.

Appendix 1 | Instructions, lists of symptoms, general items 1-3 and item 6 of the SUMD scale in SPANISH

Instrucciones

Esta escala requiere que el sujeto tenga un trastorno mental con alguno de los síntomas que se detallan más abajo. Para cada síntoma ítem de la escala primero se debe comprobar que el sujeto ha presentado este síntoma particular durante el período bajo investigación. La gravedad del síntoma no es relevante, únicamente es necesario que esté claramente presente. La verificación de la lista de síntomas debe llevarse a cabo antes de rellenar la escala a fin de determinar qué síntomas ítems son relevantes. Los tres ítems «sumarios» (números 1, 2 y 3), que no corresponden a síntomas específicos, normalmente son relevantes y deben ser cumplimentados si ése es el caso.
En la columna actual «A», se califica el máximo nivel de conciencia apreciado durante la entrevista para la psicopatología actual.
En la columna pasado «P» se califica el nivel presente de conciencia por cada ítem acontecido durante un período de tiempo anterior a la investigación en curso. En otras palabras, cuando se pregunta acerca de un episodio particular del pasado el sujeto en el momento presente podría decir que entonces él estaba delirando, con trastornos del pensamiento, sin capacidad para relacionarse socialmente, mentalmente enfermo, etc.
Se pueden utilizar períodos de tiempo más cortos o más largos para la valoración actual y retrospectiva de la conciencia y la atribución, dependiendo de los objetivos de la investigación.
En los síntomas ítems (números 4-20) se debe valorar la comprensión del sujeto acerca de la causa de su síntoma (la atribución).

NOTA: Por cada síntoma los ítems de atribución serán evaluados sólo si el sujeto ha recibido una puntuación entre 1 y 3 en el ítem de la conciencia.

Lista de síntomas

Enmarque con un círculo la «A» para actual o la «P» para pasado, situadas junto al número de ítem, para señalar qué síntomas ítems y períodos de tiempo han de ser evaluados.

Ítem			Síntoma
4	A	P	Alucinaciones
5	A	P	Delirio(s)
6	A	P	Trastorno del pensamiento
7	A	P	Afecto inapropiado
8	A	P	Apariencia o vestimenta inusual
9	A	P	Comportamiento estereotipado o ritualista
10	A	P	Juicio social empobrecido
11	A	P	Control pobre de los impulsos agresivos
12	A	P	Control pobre de los impulsos sexuales
13	A	P	Alogia
14	A	P	Aplanamiento o embotamiento afectivo
15	A	P	Desgana o apatía
16	A	P	Anhedonía-asocialidad
17	A	P	Atención pobre
18	A	P	Confusión-desorientación
19	A	P	Contacto visual inusual
20	A	P	Relaciones sociales pobres

Items generales

1. **Conciencia de trastorno mental**
   ¿En términos generales, la persona cree que tiene un trastorno mental, un problema psiquiátrico, una dificultad emocional, etc.?

A	P	
0	0	No puede ser valorado
1	1	Conciencia: el sujeto claramente cree que tiene un trastorno mental
2	2	
3	3	Conciencia intermedia: está inseguro de tener un trastorno mental, pero puede considerar la idea de que pueda tenerlo
4	4	
5	5	No conciencia: cree que no tiene un trastorno mental

2. **Conciencia sobre los efectos obtenidos con la medicación**
   ¿Qué es lo que cree la persona sobre los efectos de la medicación? ¿La persona cree que la medicación le ha disminuido la intensidad o frecuencia de sus síntomas (si es aplicable)?

Appendix 1 | **Instructions, lists of symptoms, general items 1-3 and item 6 of the SUMD scale in SPANISH**

A	P	
0	0	No puede ser valorado o ítem no relevante
1	1	*Conciencia:* el sujeto claramente cree que la medicación ha disminuido la intensidad o frecuencia de sus síntomas
2	2	
3	3	*Conciencia intermedia:* está inseguro de que la medicación haya disminuido la intensidad o la frecuencia de sus síntomas, pero puede considerar la idea
4	4	
5	5	*No conciencia:* cree que la medicación no ha disminuido la intensidad o la frecuencia de sus síntomas

3. **Conciencia de las consecuencias sociales del trastorno mental**

¿Cuál es la opinión de la persona acerca de las razones por las que ha sido ingresado en un hospital, involuntariamente hospitalizado, arrestado, desalojado, despedido, herido, etc.?

A	P	
0	0	No puede ser valorado o ítem no relevante
1	1	*Conciencia:* el sujeto claramente cree que las consecuencias sociales relevantes están relacionadas con tener un trastorno mental
2	2	
3	3	*Conciencia intermedia:* está inseguro acerca de que las consecuencias sociales relevantes estén relacionada con tener un trastorno mental, pero puede considerar la idea
4	4	
5	5	*No conciencia:* cree que las consecuencias sociales relevantes no tienen nada que ver con tener un trastorno mental

Ítem síntoma de las subescalas

6. **Conciencia de trastorno de pensamiento**

¿La persona se da cuenta de que su comunicación está desorganizada y es difícil de comprender para los demás?

A	P	
0	0	No puede ser valorado o ítem no relevante
1	1	*Conciencia:* el sujeto claramente cree que sus comunicaciones o sus pensamientos están desorganizados
2	2	
3	3	*Conciencia intermedia:* está inseguro de que sus comunicaciones o sus pensamientos estén desorganizados, pero puede considerar la idea
4	4	
5	5	*No conciencia:* cree que no tiene comunicaciones ni pensamientos desorganizados

6b. **Atribución: ¿cómo explica el sujeto esta experiencia?**

A	P	
0	0	No puede ser valorado o ítem no relevante
1	1	*Correcta:* el síntoma se debe a un trastorno mental
2	2	
3	3	*Parcial:* está inseguro, pero puede considerar la posibilidad de que se deba a un trastorno mental
4	4	
5	5	*Incorrecta:* el síntoma no está relacionado con un trastorno mental

Between 20 % and 50 % of the patients had the symptoms: hallucinations, thought disorder, inappropriate affect, stereotypes, poor social judgment and alogia, that correspond to items 4, 6, 7, 9, 10 and 13.

Items 8, 11, 12, 18 and 19 that correspond to the symptoms of unusual dress or appearance, poor control on aggressive impulses, poor control of sexual impulses, confusion and unusual eye contact, could only be evaluated in less than 20 % of the patients.

Awareness of symptoms subscale

Means and standard deviations

The mean of the total scores of the awareness subscale was 1.9 (SD = 1.04), with a range of 1 to 5.

For each one of the items, the range of the means of the scores went from 1 (SD = 0.0) (item 4, hallucinations) and item 18, confusion) to 5 (SD = 0.0) (item 8, unusual dress or

appearance). Item 19, unusual eye contact, had a greater variability 3.40 (SD = 2.19), while the smallest variability was found in items 1, 8 and 18 that correspond to hallucination symptoms (SD = 0.0), unusual dress or appearance 5 (SD = 0.0) and confusion 1 (SD = 0.0), respectively.

Intraclass correlation coefficient

The range of the ICC between the two evaluations per item of the same patient was 0.72 to 1 (mean: 0.86). The ICC for the value of the total of the subscale was 0.97.

Subscale of attribution of the symptoms

Means and standard deviations

The mean of the total scores of the attribution subscale was 3.33 (SD = 1.18), with a range of 1.43 to 5.

By items, the range of the means of the scores went from 2.60 (SD = 1.72) (item 4, hallucinations) to 4 (SD = 1.00) (item 19, unusual eye contact). Item 10, poor social judgment, had the greatest variability 3.2 (SD = 1.88) and item 19, unusual eye contact, had the least variability 4 (SD = 1.00).

Intraclass correlation coefficient

The range of the ICC between the two evaluations, per item, of the same patient was 0.75 to 0.99 (mean: 0.84). ICC for the value of the total of the subscale was 0.94.

The subscale of awareness and the subscale of attribution did not have a significant correlation (Rho = 0.22).

There is a hierarchical relationship between the two subscales, since there should be at least one intermediate awareness of the symptoms to evaluate attribution of the symptoms. Thus, the higher the score on the awareness subscale, the lower the possibility of evaluating attribution and the lower the score on the awareness subscale, the greater likelihood of evaluating attribution and showing variation. Non-correlation would indicate that the two subscales are evaluating phenomena that are at least partially independent.

External validity

Item 12 of the PANSS scale - subscale of general psychopathology – that had been evaluated independently in each patient was used to make an external validation of the scale.

Table 1 shows the correlations data between the global scores of the SUMD scale and item 12 of the PANSS scale.

Table 1 **Correlation between the scores of the SUMD scale and the score of the item of awareness of the PANSS scale in 32 stabilized psychotic patients**

Item 1. Awareness of mental disorder	0.427*
Item 2. Awareness of the effects of the medication	0.374*
Item 3. Awareness of the social consequences	0.288
Awareness subscale	0.505**
Attribution subscale	0.239

Spearman's correlation coefficient. *Significant correlation at 0.01 level (bilateral) **Significant correlation at 0.05 level (bilateral)

The general items 1 and 2, that evaluate awareness of disorder and awareness of the effect of the medication, and the subscale of awareness of the symptoms, show significant positive correlations with the item that evaluates awareness of disorder in the PANSS scale. On the contrary, no significant correlations were observed with item 3, that evaluate the awareness on the social consequences of the mental disorder nor with the attribution subscale.

DISCUSSION

The present study focuses on evaluating the psychometric properties of the adaptation to Spanish of the SUMD scale, studying its reliability and external validity in a sample of 32 patients with schizophrenia and schizoaffective disorder, admitted in partial hospitalization regime and stabilized on a psychopathological level. The results show some high intra-rater reliability coefficients on all the subscales of the instrument as well as significant correlations between the awareness of disorder item of the PANSS and those subscales of the SUMD that evaluate, strictly speaking, awareness of disorder. All of this indicates that the version in Spanish of the scale of assessment of the non-awareness of mental disorder SUMD has a reliability and external validity that are comparable with the original scale.

The scores of the items were very variable, as is to be expected when the phenomenon of the character is more dimensional than dichotomic. Furthermore, they were comparable to the results obtained with samples of similar characteristics[35-38]. On the other hand, the subscales of awareness and attribution, although partially dependent, were not correlated, this corroborating the idea that the two subscales were evaluating phenomena that were at least partially independent.

In comparison with the descriptive data of the original study, the mean scores obtained on the subscales were mildly lower, except for the attribution subscale. This could

be explained by the fact that our profile of patients is slightly different than the sample of the original work. It includes patients who are a little older, or whose disorders are more evolved and in a stabilized status of their disorder, who came to a partial hospitalization site where compliance of this psychopharmacological treatment is supervised. Thus, it could be expected that these patients may have a mildly greater awareness of their symptoms. On the other hand, the greater score on the subscale of attribution could be understood from a point of view of a contextual character since attribution is a dimension of awareness of disorder that is more related with the interpretative mechanisms of external reality and therefore more related with the sociocultural context than with the experience lived.

External validity measured through convergence with a general measure of awareness of disorder, such as item 12 of the subscale of general psychopathology on the PANSS scale, provides partial results, as was to be expected. Awareness of the social consequences of mental disorder and attribution did not correlate with the general item of the PANSS.

All of the above supports the idea that awareness (insight) is a multi-dimensional phenomenon and that the mechanisms underlying the capacity to have global awareness of the disorder, of the need for treatment, and of social consequences of the disorder may not be the same ones as those which underlie awareness of the symptoms of the disorder or for their attribution. For example, there is evidence that the neurocognitive deficits are associated more to non-awareness of symptoms – or conceptualization dimension of the symptoms as pathological - then with the dimensions of awareness of disease and need for treatment[39,40,41].

It is possible that there will be variability in awareness and in the underlying mechanisms that could be more or less specific even for each one of the symptoms. One example of the lack of correspondence between awareness of symptoms of different domains is that which occurs between awareness of abnormal movements in latent dyskinesia and awareness of mental disorder in the same group of patients[42]. We also have preliminary evidence regarding the idea that the mechanisms underlying awareness of positive and negative symptoms are probably different.

Thus, it has been observed that awareness involves differently for both types of symptoms and that the symptoms also have a differentiated correlation with the deficits of executive functions[36,43].

An elevated reliability was obtained between observers, the ICC always being above 0.70. The data supports the good design of the instrument, that is also supported in suggestions for clear and concise examination and in the practical and extended training manual.

Given the characteristics of the scale, in which the items symptom can only be evaluated if they are present and attribution can only be evaluated for the symptoms that the patient are aware of, it was not possible to conduct any study on its internal consistency in either the original version or in the present work since each one of the patients score different items.

The SUMD scale as well as other instruments designed to evaluate awareness probably partially captured this complex phenomenon. Use of this scale in its complete 20 item version is the most recommendable because it makes it possible to distinguish, on the one hand, the opinion of the patient on his/her symptoms in a differentiated way and on the other, the social consequences of the disorder and the interpretation that the patient makes of his/her symptoms. This facilitates a more global view of the patient and helps to better focus the rehabilitation interventions or improve the perception of his/her disorder.

Currently, we have no comprehensive hypotheses on this phenomenon, sometimes understood as a symptom of the psychoses, others as a cognitive deficit or cognitive goal or as a personality dimension.

Even though the instruments are not prefect, it is worthwhile to try to learn more about the knowledge of awareness of disorder in psychoses. If we take an interest in knowing what the person thinks about what is occurring, what sensation the subject has about what is occurring, where the subject finds an explanation for what is occurring, it means that we accept the subjectivity of any human experience and recognize that our work goes beyond identifying the existence of symptoms and treating them according to the protocol.

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