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**Supplementary Methods**

**Clinical and neuropsychological assessments***.* Attentional scores on the Scale to Assess Negative Symptoms (SANS) were omitted in the analysis, as proposed by the National Institute of Mental Health’s Measurement and Treatment Research to Improve Cognition in Schizophrenia (NIMH-MATRICS) consensus statement on negative symptoms (Kirkpatrick, Fenton, Carpenter, & Marder, 2006). SANS scores were the dichotomized; in normal functioning, all symptoms are considered mild and global scores are rated from 0 to 2. Functioning deficits are present when one or more global score is rated 3 or higher, corresponding to a moderate level of severity. Finally, when the abbreviated version of the Wechsler Adult Intelligence Scale third edition (WAIS III; Wechsler, 1997) was administered, the items included were Similarities, Arithmetic, Digit Span, Information, Letter-Number Sequencing, Picture Completion, Digit Symbol Coding, Block Design and Matrix Reasoning.

**Discriminant function analysis.** As the discriminant analysis was performed on the same dataset as the one used in the TwoStep analysis, the jackknife procedure was used to reduce bias due to cross-validation (Cross, 2013). This procedure performs multiple runs of the discriminant analysis, each time leaving one (different) subject out, hence minimizing the risk of confirming results by using the same data in different types of analyses (Efron, 1982).

**Supplementary Results**

**Discriminant function analysis.** Results of the discriminant function analysis showed that 39.3% of patients were correctly classified into their attributed cognitive insight group based on a set of predetermined clinically relevant variables.

**Two-Step analysis including all theoretical correlates of cognitive insight.** The silhouette coefficient of this TwoStep cluster analysis was of 0.4, which is considered medium by the criteria of Kaufman & Rousseeuw (1990). A total of 149 patients were classified in Cluster A and were characterized by cognitive deficits, lower IQ, and non-remitted positive and negative symptoms. Cluster B was comprised of 112 patients showing normal cognitive capacity, higher IQ, non-remitted negative symptoms, and remitted positive symptoms. Both clusters had similar depression scores. Independent sample t-tests showed that these clusters did not differ from each other on any BCIS subscale (Self-reflectiveness: t(259) = -.55, p = .58; Self-certainty: t(259) = .48, p = .63; Composite Index: t(259) = -.71, p = 48).

Supplementary Table 1

*Means, Standard Deviations and Ranges of Self-reflectiveness, Self-certainty, and Composite Index Scores for each Cluster Resulting from the Correlation-driven Analysis.*

|  |  |  |
| --- | --- | --- |
|  | **Cluster A** (N = 149) | **Cluster B** (N = 112) |
| **Self-reflectiveness** | 13.0 (SD = 4.4, Range = 3 to 26) | 13.3 (SD = 4.7, Range = 3 to 26) |
| **Self-certainty** | 7.8 (SD = 3.5, Range = 2 to 16) | 7.6 (SD = 3.0, Range = 0 to 15) |
| **Composite Index** | 5.2 (SD = 5.5, Range = -10 to 19) | 5.7 (SD = 6.0, Range = -10 to 22) |

*Note.* The analyses were not pursued further as our clusters did not significantly differ on BCIS scores.

Supplementary References

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