

# Knowing your own mind

**I**n mental health practice and research there is a growing user movement and a shift in how users of services are perceived. But despite this development, accounts of psychological distress are predominantly formulated by relevant professionals and have authority over individuals' own formulations. This is particularly problematic with respect to the concept of insight. In psychiatric practice, assessing a person's insight into their experience is a central component of the mental state examination (the formal record of a person's clinical presentation that is used to make a diagnosis and management plan). Given that professionals' formulations of distress predominate, what is considered to be a valid account of one's experience of psychosis? Failure to agree you have a mental illness is often considered to be symptomatic of the condition – but is mental health legislation and practice placing too much emphasis on the importance of insight?

## How is insight assessed?

In psychiatry, insight is defined as awareness of illness along with acknowledgement that the illness is mental (David, 1990). Typically, psychiatric case notes have an entry of 'good', 'partial' or 'poor' insight, without any information about how this judgement was arrived at. Even in research, measurement of insight has largely focused on quantification of presence or absence, a task similar to diagnosis that creates a simple dichotomy between the sick and the well (Pilgrim, 2000) or the insightful and insightful.

Recent studies (e.g. Weiler *et al.*, 2000) have used questionnaires such as the Insight and Treatment Attitudes Questionnaire (McEvoy *et al.*, 1989), which asks questions such as 'Do you have mental (nervous, worry) problems now?'. These are then rated as full, partial or no insight. Used in this way, insight is a very crude concept and does not promote an understanding of the complexities involved in how a person makes sense of their distress. Clinician-rated scales predominate



**ROSEMARIE MCCABE and ETHEL QUAYLE** assess the importance of insight into psychotic experience.

and there are few self-rated measures of insight (e.g. Birchwood *et al.*, 1994). Marks *et al.* (2000) suggest that there is an assumption that self-report instruments are not capable of capturing the way people with a diagnosis of schizophrenia understand and feel about their illness.

When research has been carried out to explore individual accounts of illness, it is clear that people use a range of different frameworks to understand and explain their experience (BPS, 2000). Many people, some psychologists included, do not concur with the traditional or mainstream conceptualisation of mental illness. For example, some people regard hearing voices and seeing visions as spiritual experiences rather than as signs of mental illness. Indeed, between 10 and 15 per cent of the population have heard voices or experienced hallucinations (Tien, 1991) – most of these people do not have a psychiatric diagnosis. However, from the perspective of many of those who provide psychiatric services, failure to agree that one has a mental illness is considered to be symptomatic of one's condition.

## Why now?

Insight into illness has received considerable attention recently, particularly in relation to the concept of schizophrenia – so much so that lack of insight is being discussed as a possible diagnostic feature (Amador & Kronengold, 1998). The bulk of research in this area focuses on the clinical correlates of poor insight, such as symptom severity, neuropsychological impairment and structural brain damage (e.g. Larøi *et al.*, 2000; Weiler *et al.*, 2000).

Contrary to expectations, it appears that insight is not adequately accounted for by

these factors (e.g. Collins *et al.*, 1997; Sanz *et al.*, 1998). Yet research into the psychological and social factors that modulate the expression of insight is negligible. Meanwhile in everyday clinical practice the cursory treatment of insight is far from satisfactory, considering its assessment has such far-reaching consequences for treatment decisions, legal interventions and ongoing treatment monitoring.

## The new 'community treatment order'

One such legal intervention is the proposed 'community treatment order' (Department of Health, 1998). If introduced, this would allow the administration of medication against a person's will in the community, which previously could only take place on admission to hospital. In discussions over the introduction of this order, it has been suggested that 'lack of insight' manifested in repeated non-compliance with treatment and relapse should be sufficient to impose involuntary treatment (e.g. Kennedy, 1999). However, a look at the relevant research flags up a major flaw in this approach. Insight explains only a limited amount of the variance in compliance, especially in chronic illness (McCabe *et al.*, 2000). Many people considered to have insight do not take their medication, while many others thought to lack insight willingly take medication (e.g. Garavan *et al.*, 1998).

As Buchanan (1996) has pointed out, it is a myth that people with a psychiatric diagnosis are less compliant than any group of medical patients. Service users feel unhappy about how current mental health policy stresses the need to monitor and control people receiving care in the

community, while it overshadows the action they themselves take in managing their medication (Rogers *et al.*, 1998). Contrary to the predominant view in psychiatry, non-compliance may be understood as rational choice rather than irrational action (lack of insight), particularly given the side-effects of long-term psychotropic medication. Of all factors associated with discontinuing medication, unpleasant side-effects are found to have the strongest association (Kampman & Lehtinen, 1999). Unwanted side-effects include weight gain, impotence, involuntary movements and akathisia (a feeling of inner restlessness) – many people find these more distressing than the original symptoms for which they were treated (Rose, 2001).

### **How we see ourselves: Rose-tinted glasses?**

The notion of insight is interesting in a context wider than that of mental health, as it is concerned with how we view ourselves, and how we account for our actions in the world. It is now well established that our thinking processes are characterised by inaccurate perceptions of ourselves and our environment. We tend to see ourselves as better than others, to have exaggerated perceptions of personal control even when events are actually determined by chance, and to be overly optimistic about our personal future (Taylor & Brown, 1988).

Given these findings in 'normal' thinking, is it not surprising that when called to account for psychological distress, one will overestimate positive and underestimate negative functioning and be unrealistic about the impact of the experience and the need for treatment in the future. From the clinician's perspective an unrealistically positive view of the self and an exaggerated perception of self-control in this context will diverge from their assessment (which is professionally rather than experientially informed) and will be attributed to poor insight.

### **Adding insight to injury**

How we see ourselves and maintain positive mental health has implications for current thinking about insight – that 'more insight is better'. The function of denial as a psychological defence mechanism (protecting a person from threatening external events) is integral to mainstream thinking about coping with physical illness (e.g. Goldbeck, 1997), but this is not the case with psychological illness.

Among people with a diagnosis of schizophrenia Dixon *et al.* (1998) found that the less 'aware' people were of their symptoms, the less likely they were to be subjectively depressed. Increased awareness of negative symptoms and delusions was significantly associated with recurrent suicidal thoughts (Amador *et al.*, 1996). Similar results were reported by Moore *et al.* (1999), who concluded that 'the presence of depressive symptomatology in schizophrenia is related to the level of insight, and contingent at least in part on the absence of

self-deception as a denial defence' (p.264). In line with these findings, attributing one's problems to a 'mental illness' rather than a 'physical, medical or biological' problem is associated with reduced subjective quality of life (Mechanic *et al.*, 1994).

Given these associations between insight and mental health, suggesting that 'ignorance is bliss', what are the ethics of treatment models that focus on increasing insight – what Lamb (1986) has termed 'adding insight to injury'? These findings raise critical questions about when, how and with whom insight-oriented treatment approaches should be used.

### **Receiving and disclosing information**

Regardless of one's level of insight, the motivation to disclose the information needed for both diagnosis and treatment planning is an issue for people called to account for their experience. In somatic illness (e.g. asthma) people restrict how much they tell others about their illness because of the consequences for their social identity (Adams *et al.*, 1997).

A diagnosis of schizophrenia is a highly stigmatised condition, and the media portray such people as dangerous, violent and unpredictable (Leudar & Thomas, 2000). Consequently many people readily acknowledge that they will not divulge information about psychotic experience, responding to the suggestion with 'Are you mad?'

In the clinical domain divulging such information may increase the likelihood of compulsory admission to hospital and further loss of autonomy (BPS, 2000), resulting in people playing down their difficulties. The current approach tends to put people who are undergoing strange and frightening experiences in a defensive position, rather than fostering understanding and reassurance, by 'testing' their beliefs about themselves when they are already often unsure about what is happening.

The amount of information 'available' to the client is clearly important for insight. There is wide variation among psychiatrists in what they communicate about their diagnoses, although there is a high correlation between levels of client satisfaction and the amount of information professionals provide about the nature of mental illness, its causes and treatment (Barak *et al.*, 2001). In a psychiatric ward Shergill *et al.* (1998) found that over half the people there had not been told their diagnosis although most wanted to know. Interestingly, people who have had more contact with services or who receive psychoeducation are deemed more insightful (Macpherson *et al.*, 1996). Though receiving information about how clinicians talk about and treat psychosis is useful, it should also be the case that people have a chance to construct their own interpretations of this experience.

### **The role of personal accounts**

There is a growing interest in narrative accounts of illness (e.g. the recent series in the *British Medical Journal*) and their role in helping people accommodate difficult events. As insight, by its very definition, is

## **WEBLINKS**

DCP report on understanding mental illness:

[www.understandingpsychosis.com](http://www.understandingpsychosis.com)

National Schizophrenia Fellowship: [www.nsf.org.uk](http://www.nsf.org.uk)

The Hearing Voices Network:

[www.hants.gov.uk/listcclr/cch33222.html](http://www.hants.gov.uk/listcclr/cch33222.html)

Centre for Evidence Based Mental Health Care:

[cebmh.warne.ox.ac.uk/cebmh](http://cebmh.warne.ox.ac.uk/cebmh)

concerned with individuals' interpretations of their experience, the narrative offers a promising means of exploring insight from an individual perspective (Chadwick, 2001). A study using this approach suggested that the articulation *per se* of psychotic experience is problematic (McCabe, 1999). If our vocabulary of self-understanding (our self-discourse) is largely socially derived (Harré, 1995), where can people learn to articulate psychotic experience?

Clinicians adopt a restricted set of words (their professional vocabulary) that may or may not correspond to people's experiences. Using only clinical formulations tends to strip people's experiences of its meaning, as indicated in the following quote: 'They diagnosed me as being schizophrenic. I don't know a lot about schizophrenia. I get mood swings myself... I don't really know what it means except that you're supposed to have a split personality. I suppose that's why I get my highs and lows.' (McCabe, 1999, p.388.)

Yet people are called to account for psychotic experience according to the clinical formulation. As both the Division of Clinical Psychology report (BPS, 2000) and Pilgrim (2000) highlighted, ordinary-language descriptions are much more sensitive to the psychosocial context of behaviour and experience and are more meaningful to people in coming to terms with and managing the possibility of recurrent distress.

### Where do we go from here?

Firstly, it is necessary to reconsider the current definition of insight, taking into account the self-serving biases that characterise 'normal' thinking in how we view ourselves and our environment. In addition, it seems clear now that insight is not an all-or-nothing phenomenon – it fluctuates according to where, with whom and how it is elicited. In the light of the new mental health legislation, awareness should be raised that non-compliance with treatment is largely not explained by poor

insight. Research to establish the consequences of promoting insight when people are already highly vulnerable should be conducted. Clinicians in psychiatric practice should generally be encouraged to provide more information to service users, which clearly improves satisfaction. Finally, anyone who experiences psychosis should be helped to talk about their experience without feeling intimidated by the possibility that what they say will be used in what are perceived as negative ways. The real challenge lies in creating this space as a matter of course in clinical practice; a space where clinicians and service users can engage in an exchange that fosters mutual understanding rather than alienation.

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