FRONTLINE PERSPECTIVES

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Insight as a Bridge and not a Barrier to Patient-Centered Psychiatric Care

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Abstract

This paper examines the ethical implications of insight in psychiatric care through case studies, highlighting how its ambiguous definition can either hinder or enhance the patient-physician relationship. Insight, as a term, is sometimes used as a proxy for other important concepts, such as decisional capacity and treatment adherence. These qualities are essential but should be clearly defined and addressed separately from the broad, often ambiguous concept of insight. I propose reframing insight as a means for empathetic understanding and patient self-awareness, viewing it as an opportunity for shared education and therapeutic alliance. When understood as a window into the patient's perspective, insight can support shared decision-making that respects patient agency while acknowledging the gap between clinician and patient views of illness. I argue that this approach begins with intentional clinical discussions about its meaning and limitations. Recognizing insight as an opportunity to explore a patient's narrative, rather than a judgment laden with assumptions, may strengthen the partnership between clinician and patient.

Key Words: insight, psychiatric ethics, therapeutic alliance, shared decision-making

Introduction

In psychiatric care, insight is frequently discussed as an important factor in guiding treatment, yet it is rarely well-defined and often carries assumptions, making it a complex and ethically nuanced construct. As part of the canonical mental status exam, insight is rated on a poor-fair-good scale, often applied without substantial justification. Typically defined as a patient's self-awareness of their mental illness, insight is often treated as a proxy for recovery readiness, treatment adherence, and decisional capacity (Guidry-Grimes, 2019). While insight intersects with these domains, it is not synonymous with them; patients may lack insight yet still demonstrate recovery readiness, adhere to treatment, and

possess decisional capacity.

The disconnect between a patient's perception of their mental experiences and the diagnoses assigned to them can stem from various factors, including health literacy, stigma, distrust, self-concept, rejection of illness, and cultural influences. Importantly, psychiatric illness itself can impair insight, particularly in psychotic disorders such as schizophrenia, as well as in bipolar and other mood disorders. Studies have shown a correlation between the severity of psychopathology and impaired insight (David & Ariyo, 2020). The complexity of accepting a psychiatric diagnosis is well captured in *An Unquiet Mind*, where Dr. Kay Redfield Jamison reflects on her experience with bipolar disorder:

> The intensity, glory, and absolute assuredness of my mind's flight made it very difficult for me to believe, once I was better, that the illness was one I should willingly give up... Moods are such an essential part of the substance of life, of one's notion of oneself, that even psychotic extremes in mood and behavior somehow can be seen as temporary, even understandable reactions to what life has dealt. (Jamison, 1996)

Mental phenomena - whether distressing, impairing, dangerous (e.g., suicidality), or detached from reality (e.g., delusions, hallucinations) - are deeply personal. For individuals with mental illness, coming to terms with their condition involves a gradual process of distinguishing their thoughts, emotions, and perceptions from the illness itself. Unlike a malignant tumor, which is often perceived as an external entity invading someone, psychiatric symptoms are intimately tied to one's sense of self. This process of acceptance requires time, empathy, and support, making it both a challenge and a privilege in psychiatric care.

Ethicist Curk explains the complexity of accepting insight through a four-step process, illustrating how challenging this journey can be for patients (Curk et al., 2020). The first step involves recognizing, on an internal level, that something about one's experiences may be unusual or troubling. The second step requires making sense of the labels and descriptions provided by the clinical team, a process influenced by one's cognitive abilities and sociocultural background. Language plays a central role here. The psychiatric vernacular is inherently technical and can feel foreign or stigmatizing to patients, creating a disconnect between their self-perception and the terms applied to them. The third step is to connect these labels to one's own experiences and begin to accept the possibility of possessing an undesirable characteristic, such as a mental health disorder. Finally, the fourth step involves publicly

acknowledging this connection in front of the clinician or care team, accepting an external view of oneself as part of one's identity. This stepwise approach highlights the complexity and depth of achieving insight. Insight assessments often reflect clinicians' perspectives, potentially overshadowing patients' protective or culturally rooted narratives (Amador & Kronengold, 2004; Dell'Osso et al., 2002). Cultural and socioeconomic factors shape both patients' understanding and clinicians' perceptions of insight (Amador et al., 1991; Curk et al., 2020). Patients may adopt clinical language to appear compliant with unfamiliar terms, but without genuine acceptance, limiting dialogue (Lincoln et al., 2007).

Case Studies

I will focus on case studies from two patients with bipolar disorder. Bipolar disorder provides a compelling case study for examining the concept of insight as it demonstrates the dynamic nature of this phenomenon. During acute manic episodes individuals with bipolar disorder often experience a significant decline in insight, failing to recognize the abnormality of their thoughts and behaviors (Cassidy, 2010). As the manic phase subsides, patients may regain some level of insight, acknowledging their departure from baseline functioning. However, recognizing the delusional beliefs that often accompany mania can be a more protracted process, sometimes taking years or remaining unresolved (Aminoff et al., 2022). This dynamic fluctuation in insight highlights the complex interplay between biological factors and subjective experience in mental illness. In the case of bipolar disorder, the dynamic nature of insight highlights the need for a nuanced approach to addressing insight.

Case 1

A 44-year-old patient was admitted to an inpatient psychiatry unit “exhausted” from a 10-day stretch of travel, concerts, gambling, and lobbying activities, with little sleep. He attributes his recent behaviors to a traumatic brain injury (TBI) sustained a decade ago, though his history shows a diagnosis of bipolar disorder in his twenties, stabilized on medication for two decades until he discontinued it four years prior, and no prior TBI. He has recently created the TBI narrative, rejecting bipolar disorder yet agreeing to mood stabilizers to manage the uncomfortable symptoms that the patient attributes to TBI. He disengages from discussions involving a bipolar diagnosis, maintaining his belief in the TBI as the cause.

Case 2

A healthcare professional was admitted to an inpatient psychiatry unit experiencing somatic and persecutory delusions within a manic episode. With a history of hypomanic and depressive episodes, she has been unemployed for two years, despite formerly enjoying a successful career. Although her symptoms align with bipolar disorder, she denies the diagnosis, preferring to term her condition an "unspecified mood disorder." She agrees to lithium for this "unspecified disorder," citing her familiarity with it from recommending it to her own patients.

Case Discussion: The Implications of "Poor Insight" & Insight as Bridge

In each of these cases, the patients lacked some level of self-awareness regarding their illness, and this lack of self-awareness complicated treatment. These patients sought treatment for distressing experiences but were having difficulty accepting a psychiatric diagnosis.

These patients could have been labeled as having poor insight, which without thorough investigation may lead to assumptions. If the patient's narrative is not thoroughly explored, they may feel that their experiences are being minimized or dismissed. In an acute setting, gaining self-understanding into one's mental phenomena is an unlikely goal. Similarly, this labeling could lead to assumptions about treatment adherence, with further discussions about treatment options being prematurely limited. This disconnect risks obscuring the patient's underlying beliefs, stigma, or prior psychiatric experiences.

Alternatively, when the treatment team recognized the patient's ambivalence toward a diagnosis and emphasized their willingness to engage in treatment, the discussion was tailored to understand the patient's rationale. This approach reframes insight as an entry point for seeking to understand each patient's perspective.

In Case 1, engaging the patient in discussions about his perceived instability provided a foundation for constructive dialogue. Through conversation, the team learned that he had faced life challenges, such as strained family relationships, professional setbacks, and difficulties in forming romantic connections. These frustrations fueled his reluctance toward accepting a bipolar diagnosis because despite treatment, he was not progressing in the way he desired. Additionally, the team noted that a learning disorder may have affected his comprehension, influencing how treatment information was best conveyed. Recognizing these factors, they focused on the benefits of mood stabilizers, supporting his comfort with treatment without requiring immediate acceptance of a diagnosis. Therapy

was engaged at understanding the patient's view of his diagnosis impeding his life goals, and discussions around measures for life-improvement provided encouragement for the patient. Over time, as he stabilized, a long-term plan with his therapist was established to gradually explore the bipolar diagnosis in a way that would foster self-acceptance and promote his flourishing.

Similarly, in Case 2, through focusing on the patient's descriptions of mood changes and the distress they caused, the patient shared that her reservations stemmed partly from her professional background in mental health, where she had witnessed stigma faced by patients with psychiatric diagnoses. For her, identifying her condition as "unspecified" provided a way to accept treatment while distancing herself from stereotypes associated with bipolar disorder. As her mania subsided and her insight improved, the treatment team supported her in addressing this stigma while aligning her treatment plan with her goals.

In these cases, the treatment team's approach prioritized understanding the patients' perspectives, using insight as a bridge to care. The focus remained on supporting each patient's engagement in treatment rather than emphasizing diagnostic acceptance.

These cases demonstrate that the treatment team's clinical knowledge of the patients' experiences with bipolar disorder may not correspond with the patients' own understanding or acceptance of their condition. This discrepancy highlights that the team's and patients' perspectives and importantly, language, do not need to be completely aligned for treatment to be effective. An individual's experience of mental illness may not mirror the clinical diagnostic criteria. When patients feel heard, understood, and respected, the quality of care can improve. The partnership between clinician and patient is therapeutic and central to psychiatric intervention (Krupnick et al., 1996).

Clinical Considerations of Insight

The purpose of assessing insight is not to add another label or heuristic; rather, it should serve as a bridge for exploration. Insight is best approached as a flexible tool to facilitate understanding, not a one-size-fits-all concept. While insight can be loosely defined as "self-understanding" within a psychiatric context, it should be disentangled from the assumptions that accompany it. Clinicians should be mindful that much remains unknown about insight and recognize the many factors - biological, psychological, social - that influence a patient's self-understanding in clinical settings. Insight is influenced by the interpersonal dynamics between patient and practitioner, and this

relationship, influenced by the patient's baseline personality structure and experiences, may impact the patient's openness to consider the practitioner's perspective, and thereby, the practitioner's assessment of the patient (Curk et al., 2020; Guidry-Grimes, 2019). Approaching insight as a bridge may encourage clinicians to approach a patient's self-understanding in a fluid way.

Secondly, I support ethicist Guidry-Grimes's recommendation that documentation of insight should go beyond the superficial and often ambiguous "poor-fair-good" scale commonly used (Guidry-Grimes, 2019). Documentation should capture self-understanding in a nuanced manner with explanation. This approach to documentation may reflect the patient's experience more accurately.

In the era of open notes, where patients can access their psychiatric records, there is ongoing debate about how this transparency affects patients' perceptions of psychiatric care. Some see open notes as a tool for fostering openness, allowing patients to explore their clinician's documentation, which can enhance collaborative care (Schwarz et al., 2024). Others, however, caution that unclear, jargonistic, or stigmatizing language may alienate patients and reinforce negative perceptions of psychiatry, particularly if they feel judged by labels or assumptions. In this context, expanding documentation around insight could be beneficial.

The topic of insight is part of a larger academic debate. Scholars like Guidry-Grimes and Curk argue that insight is often misapplied as a judgment or label, potentially undermining patient autonomy. Others, like David and Ariyo, suggest that insight remains a valuable construct with strong clinical validity when applied thoughtfully. My perspective, shaped by my experiences as a trainee, proposes emphasizing insight as a collaborative exploration rather than a fixed criterion.

Conclusion

Insight is a valuable concept because eliciting a patient's self-understanding while acknowledging the complex and dynamic nature of it provides an opportunity to connect with patients, finding avenues to treat them within their own understanding. When insight is approached in this light, the clinician exercises humility and curiosity while bolstering the therapeutic relationship. Furthermore, explicitly disentangling insight from assumptions about capacity, treatment adherence, and self-knowledge ensures that these assessments of insight do not implicitly lead to assumptions about these related but not synonymous concepts. This approach ensures that insight facilitates partnership between clinician and patient.

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