Insight and Interpretation of Illness in Recovery From Psychosis

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Abstract

The concept of insight as it applies to patients suffering from psychotic illness is reviewed. An exploratory study using structured interviews with patients recovering from psychotic illness indicated that the characteristics of insight fell into five main dimensions: (1) views about symptoms, (2) views about the existence of an illness, (3) speculations about etiology, (4) views about vulnerability to recurrence, and (5) opinions about the value of treatment. Some preliminary findings regarding the association of patterns of insight with diagnosis and chronicity of illness, and the implications of these findings for clinical work and for future research, are presented.

Insight, a psychiatric patient’s capacity for understanding his or her problems, has typically been considered important for engagement in treatment, for psychotherapeutic progress and for prognosis. However, with the psychoses, perhaps because lack of self-awareness has been assumed, there has been little attention to whether a patient’s insight into psychosis played more than a modest role in treatment or outcome. Some clinicians who used exploratory methods for treating psychotic patients before the psychopharmacological era commonly emphasized that the patient’s subjective experience of his illness and treatment was of fundamental importance (e.g., Mayer-Gross 1920). Yet, the relevant information generated about such understandings has not been synthesized, nor has this interest in subjective experience been pursued in relation to current treatment approaches. With few exceptions (e.g., van Putten and May 1978; Greenfeld 1985), there have been remarkably few systematic descriptions of the views of psychotic patients undergoing treatment with antipsychotic medication concerning their illness or their treatments.

In recognizing these deficiencies, it is important to note that although the concept of insight is widely used in psychiatry, there is not even a commonly accepted definition for this term. In fact, “insight” has acquired a variety of meanings (Tolor and Reznikoff 1960; Hobbs 1962). Psychoanalytically oriented clinicians identify two distinct types of insight: intellectual insight and emotional insight (Martin 1952; Zilboorg 1952; Richfield 1954). Intellectual insight refers to a person’s capacity to identify important personality traits, conflicts, developmental issues, and stressful life events that might play a role in generating psychiatric symptoms or illness. Emotional insight refers to a more profound capacity to achieve a “therapeutically effective understanding” of unconscious motivations and conflicts, an understanding usually developed in the context of a dynamic psychotherapy.

General or descriptive psychiatrists, on the other hand, commonly employ a broader notion of insight focusing merely on whether patients believe they have a mental disorder or not. In reporting the mental status examination, for example, this general notion is usually reflected in a single sentence to the effect that the patient has “good insight” or “poor insight.” This more limited concept of insight is reflected in the World Health Orga-
nization (WHO) International Pilot Study of Schizophrenia (Carpenter, et al. 1973), which defined insight as the patient’s capacity to acknowledge some awareness of having an emotional illness. Lack of insight was defined simply as denial of illness.

Although the psychoanalytic and the general concepts of insight may be important, they fail to do justice in describing what the patient’s view of psychosis actually involves. There is also the danger that they equate “insight” with sharing the clinician’s views rather than possible alternative viewpoints. The traditional notions of the characteristics of insight ignore a variety of potentially important questions, especially the range of patients’ views of their problems and how these problems can be overcome.

Recently, the psychotic patient’s capacity for insight has been the focus of increasing interest as treatment strategies have come to include community care programs and as treatment approaches have evolved in which stabilized psychotic patients report early signs of exacerbations so that medication can be given promptly (Herz and Melville 1980; Carpenter and Heinrichs 1983; Herz 1984). There has also been increasing recognition of the diverse ways in which patients take an active role in influencing the course of their disorders (Strauss et al. 1987). Clearly, such activity is likely to be strongly shaped by the patients’ conceptions of their disorder and treatment.

Some findings have also shown that for psychotic patients there are some associations between insight and outcome. Soskis and Bowers (1969) found that a positive attitude toward the psychotic experience at followup correlated significantly with good outcome. Van Putten et al. (1976) found that chronic schizophrenic patients with insight acknowledging their disorder (as defined by the World Health Organization [1978] criteria) were more likely to comply with their medication regimen than were patients without insight.

Despite this increased psychiatric focus on the insight of psychotic patients (and several studies in anthropology and sociology [Lally 1989]), there is remarkably little clinical research about the various ways in which patients come to understand the experience of psychosis. A limited amount of systematic research on the characteristics of patients’ responses to their psychotic disorders has provided some useful concepts that go beyond previous assumptions. Even these studies, however, have been restricted in amount and scope. One group of investigators, influenced by psychoanalytic conceptions, has suggested that “integration” and “sealing over” are the two major poles of a global continuum for patients viewing their psychotic pathology (Levy et al. 1975; McGlashan et al. 1975, 1976). Sealing over describes a process often encountered in convalescing psychotic patients that involves denial of the existence and/or severity of illness, high expectations for immediate return to normal functioning, and an impaired ability to recall or describe the period of acute psychosis. In contrast, the patient who is “an integrator” during recovery from psychosis is interested in exploring the psychotic experience and wishes to understand it and place it into some coherent perspective.

More recent research has implied that insight may be more complex, or at least different from the “integration/sealing over” conception, but has tended to collapse these complexities into a single global “insight level.” Lin et al. (1979), studying a group of chronic schizophrenic patients, defined insight as a unitary entity involving the “recognition of the existence of problems and the need for medical intervention” (p. 430). The following characteristics were used as criteria for this global judgment: (1) Recognition of the need for hospitalization; of the need to see a psychiatrist; or of the need to see a doctor. (2) The perception of benefit from treatment as indicated by a positive response to the question: “While you were in the hospital, did the medication do you any good, harm, or did the medication have no effect whatsoever?”

McEvoy et al. (1981) used a semi-structured interview containing 10 items, comprising three clusters of insight-related questions addressing (1) awareness of need for hospitalization; (2) awareness that illness was still active; and (3) reported need for medication. Responses to the three clusters of questions were combined to make a global judgment about the patient’s “insight.”

The authors found a correlation between awareness of active illness and patients’ reported need for medication. These studies did not examine systematically the characteristics patients chose to emphasize in understanding their psychosis nor did they attempt to explore whether patients actually had logically coherent views or whether different aspects of insight were relatively separate from each other.

To expand the scope of previous efforts, and clarify the characteristics of insight in psychosis and their association with treatment collaboration, we have undertaken an exploratory study. Our purpose is to describe and conceptualize the understanding that patients with psychosis have of their disorder.
and treatment. In this report, we present the results of our study, suggesting that the traditional views by professionals of insight in patients with psychotic disorders only partially reflect the complex texture of ideas and explanations held by psychotic patients as they attempt to make sense of their experiences and treatments.

Methods

A series of interviews was conducted with patients recovering from acute psychotic disorders focusing on how the patients viewed their disorder in terms of its symptoms, classification, origins, prognosis, and the relevance of treatment approaches. We then reviewed the patients' descriptions to determine how their conceptions fit with traditional notions of insight and interpretation of illness discussed in the literature, and whether the patients' conceptions correlated with demographic or clinical variables.

To carry out this exploration, a series of interviews was conducted with 21 patients diagnosed as having functional psychotic disorders and admitted to the Psychiatric Inpatient Division of Yale-New Haven Hospital. Functional psychotic disorder was defined as a disorder involving no clear organic cause and in which symptoms such as delusions, hallucinations, bizarre behavior, and/or severe thought disorder were documented clearly. Patients with a history of substantial drug or alcohol abuse were excluded from the study. Subjects included 12 female and 9 male patients. One subject was black; the remaining 20 were white. Social class (Hollingshead-Redlich 1958) ranged from Class I to Class V (mean = 2.5). Subjects ranged from 16 to 63 years of age (mean age = 30.5 years). This was the first psychotic episode for 11 subjects.

Diagnoses, made on the basis of DSM-III criteria (American Psychiatric Association 1980), included schizophrenia (n = 9), bipolar disorders (n = 5), unipolar depressive disorder with psychotic features (n = 4), and atypical psychotic disorder (n = 3). All of the interviewed subjects were receiving antipsychotic medication as well as some combination of interpersonal treatment (individual, group, family, and milieu therapy). Interviews were usually conducted between 4 and 12 weeks after admission after florid psychotic symptoms had subsided. One interview, about 40 minutes in length, was held with each subject. All interviews were conducted by the authors of this report.

In the beginning of this work, we asked a number of pilot subjects to talk freely about their experience and treatment, encouraging them to elaborate whatever seemed significant to them. Subjects' responses varied widely, both in the degree of elaboration and in the range of their concerns and hypotheses. Nonetheless, as we gained experience, we found that subjects' observations tended to fall into one of five major areas: (1) description and discussion of symptoms; (2) opinions about whether symptoms were manifestations of an illness; (3) speculations as to causes of symptoms or illness; (4) opinions about treatment; and (5) opinions about vulnerability to relapse and prevention of relapse. Each patient did not necessarily address all of these areas. For example, a patient who denied illness and symptoms would likely (but not invariably) find the concepts of treatment and vulnerability to relapse irrelevant. However, essentially all of the views expressed by subjects fell within the conceptual framework of these five areas. After the pilot interviews suggested these categories, we developed a semistructured interview including questions on each of these areas.

The semistructured interview started with an open-ended section. Each of the subjects was encouraged to discuss the experience which resulted in hospitalization and to describe in detail his or her understanding and views about the experience. The more structured part of the interview included a request for the patients to describe their symptoms in detail and to discuss the implications, causes, and seriousness of the symptoms. Subjects were asked whether they viewed their problems as an illness and, if so, whether they viewed it as a mental illness. In any case, they were asked if they had decided on a name to characterize or describe their experience. Subjects were asked if they had formulated views on the causes of their problems, both immediate and root causes. They were asked about their treatment, both medication and interpersonal therapies, and they were asked to report their opinions of the effects of the treatment, whether helpful or harmful. In addition, subjects were asked to speculate about the likely course of their problems, both with regard to their ability to prevent a recurrence of symptoms and with regard to the role of treatment in reducing vulnerability to relapse.

Results

In contrast to our expectations, patient reports did not reflect clear global categories with regard to insight into the psychotic experience. Patients presented an amazingly broad range of views...
about their psychoses. All of the subjects we interviewed appeared to be struggling actively to adapt to the fact that they were now patients in a psychiatric hospital. Discussions about the experience tended toward complexity, typically falling into the five distinct areas described above. A few subjects were guarded and terse in their comments, but most were willing to talk at length. Some presented views that were coherent and well integrated, but others had somewhat fragmented views that often were ambivalent or contradictory. For example, one subject explained his presence in the hospital by saying:

There’s nothing wrong with me. I had a sort of a breakdown, a mental failure, or maybe a moral failure. Other people say I’m sick, but I’m not so sure. I suppose deep down I know there’s something wrong with me, but most of the time I feel fine. I guess I lost touch with reality for a while. I was hearing voices, but it was mostly situational.

These subjects often needed time to explore their views in order to reach conclusions about which of their opinions seemed best to reflect their overall opinion. In some instances, subjects remained uncertain or torn between conflicting views.

As in the early pilot interviews, a systematic review of all 21 semi-structured interviews indicated that characteristics relevant to insight fell into five main dimensions:

1. Symptomatology. The first dimension involved the patients’ views about their symptoms. Our subjects’ reports ranged over a continuum from massive denial of symptoms to detailed discussion and clear description of them. Five patients either regarded symptoms as insignificant and trivial or denied psychotic symptoms altogether, insisting that hospitalization was the result of misunderstanding or merely “for a rest.” For example, one woman reported, “My husband brought me here. I have no idea why. There is no reason for me to be in the hospital.” Others dismissed symptoms as insignificant:

I took an accidental overdose of sleeping pills and everyone made a big deal out of it. I was seeing a psychiatrist because I was hearing voices, but it wasn’t anything serious. There isn’t anything really wrong with me.

Eleven patients gave a reasonably detailed discussion of the psychotic symptoms they suffered in the period immediately before hospitalization. The seven remaining patients were puzzled and uncertain, presenting a complex mixture of acknowledgment and denial of symptoms which located these subjects toward the middle of the continuum. One of these subjects described his symptoms as follows:

I became slightly paranoid. I was on some kind of a high, so I was slightly paranoid and slightly euphoric. I imagined all sorts of things. I thought the other guys on the team were planting microphones in my bed. I was afraid they wanted to get me in some way. I also thought I was special in some way, that the radio was signaling to me. My imagination really went kind of wild. I don’t think I was crazy or anything.

2. Existence of an Illness. The second dimension of patients’ insight into the psychotic experience involved their views about whether they suffered from a psychiatric illness. The acknowledgment and description of psychotic symptoms did not necessarily lead patients to identify themselves as suffering from such an illness. In fact, seven patients who were able to give detailed descriptions of their psychotic symptoms also minimized or denied the existence of psychiatric illness. Six of these seven patients had been hospitalized for the first time. These patients tended to categorize their experience as “an episode,” “exhaustion,” or a transient toxic state. For example, one woman reported:

I was hearing voices and I got very confused. My ex-husband came over and I had a bourbon. It was a very old bottle. It was sitting in the cupboard for years. I think it went bad and it made me sick. It was like a bad trip on drugs. I thought I was the Ayatollah, and I kept hearing Stevie Wonder’s voice asking me for help. I’ve been having trouble with my ex-husband lately. I guess he upset me. There’s really nothing wrong with me.

Conversely, three of the subjects who minimized or denied having psychotic symptoms believed they suffered from a psychiatric disorder. Thus, one young woman who minimized her psychotic symptoms insisted:

I don’t think I lost touch with reality. I just had a depressive episode and it upset and confused me. I know I need treatment to prevent a relapse.

A majority of patients, and in particular patients who had suffered their first psychotic experience, fell somewhere between these extremes. They regarded the experience as perhaps reflecting a considerable problem but still as an isolated and unique event in their lives. Thus, they might be willing to discuss some psychotic symptoms in detail, but were reluctant to
label themselves as ill in any way that might imply a continuing vulnerability to relapse. For example, one subject insisted the symptoms were caused by "difficulty dealing with a high-stress job. I just need to get a more comfortable work situation." Another commented, "I guess it means I have some problems. Maybe this episode happened because I feel no one loves me. Maybe it's because I have a low blood sugar."

3. Etiology. The third dimension of the psychotic experience that our subjects described was their views about the causes of their psychotic symptoms. Although many patients initially provided explanations that they thought we wanted to hear, nearly all could be persuaded that we were interested in their private opinions and they were generally pleased to have the opportunity to express their personal views. Some patients confided their speculations tentatively and hesitantly, while others asserted their views with conviction and confidence once assured that they would not be contradicted, humiliated, or in any way challenged.

Every patient who acknowledged psychotic symptoms had generated some causal hypothesis about the genesis of symptoms. These causal speculations ranged over a wide variety of possibilities from psychotic explanations of symptoms to hereditary factors, physical illness, drug and toxic precipitants, general life stresses, longstanding conflicts, personal or moral failures, developmental problems, and traumatic changes in various aspects of life including occupational, social, and family situations. Typical comments included the following:

Maybe my subconscious was bothering me. I guess I wasn't living my life properly. I was smoking too many cigarettes. I felt guilty for hurting my parents.

Financial problems are the main cause of all my troubles. I was on a tight budget. I had to do all the shopping, laundry, cooking, and housework.

Maybe it was my diet. I wasn't eating right. Maybe pressure from schoolwork was a factor, maybe the LSD I took last year. Sometimes I attribute everything to God's will.

I think it's a displacement activity, a moral failure, an excuse for not doing anything. I don't have the full complement of courage. I'm weak, that's the problem.

The main cause is family problems. We have a poor family life. Too many arguments between my parents. It could also be a lack of lithium in my bloodstream. I also have a very poor self-image.

There is no reason for my breakdown. It's like getting some horrible disease, like getting hit by lightning.

Most patients thought their problems were caused by a mixture of factors and no simple grouping of speculative hypotheses was apparent. Patients who emphasized biological, hereditary, or somatic hypotheses frequently also discussed personal problems and family conflict as significant additional contributors to their psychosis. Those patients whose causal speculations emphasized interpersonal or conflict-oriented hypotheses were not necessarily those with the most flexible or sophisticated capacity to explore and describe the psychotic experience.

4. Vulnerability to Recurrence. The fourth dimension concerned patients' views about their vulnerability to recurrent psychosis. Each patient interviewed had formed ideas about his or her vulnerability to relapse. All of our subjects dreaded relapse, and none thought the psychotic experience a beneficial one. For most subjects, the question of recurrent psychosis generated intense anxiety, evoking images of chronic illness. Four of the five patients who denied or minimized psychotic symptoms also asserted a confident invulnerability to the future occurrence of such symptoms: "I know this will never happen to me again. I can't tell you why, but I'm absolutely sure of it."

The remaining patients described their concern about recurrent psychosis and seemed to be struggling to be optimistic about their prognosis. The self-esteem of many of these patients appeared to depend on their capacity to exercise mastery and control over their vulnerability to relapse. The majority of subjects felt that relapse was unlikely and that their behavior and degree of self-awareness would significantly influence their future vulnerability to psychosis. They usually proposed behavioral strategies that followed more or less logically from their causal speculations about their psychotic decompensation. In fact, a number of patients appeared to give particular emphasis to causal explanations for their episodes which suggested that relapse was unlikely or which implied enhanced control over vulnerability: "I need to be careful to get enough sleep and avoid overwork. As long as I do that I'll be o.k."

5. Value of Treatment. The fifth and final dimension of insight into the psychotic experience concerned the ideas subjects had formed about which (if any) of their treatments had been beneficial, and which were likely to have continuing value for prophylaxis against recur-
rent psychosis. Patients' views of the relative merits of antipsychotic medication or psychotherapy did not necessarily correspond to their expressed views about the nature and causes of their symptoms and disorder. For example, a patient who emphasized physical and biological causes for his psychotic experience might still rate psychotherapy as the most important element in his strategy to prevent relapse. Similarly, patients who emphasized interpersonal and family conflicts as the major precipitants for their psychotic experience might still rate antipsychotic medication as the crucial element in prophylaxis against recurrence.

Several patients expressed a willingness to participate in treatment after discharge from the hospital in deference to the views of their psychiatrist, although they had considerable doubt about the validity of the information they had received from psychiatrists about their condition and treatment. They gave the impression that they would "play it safe for the time being," and comply with professional recommendations. This group of patients also suggested that once they were less frightened about recurrence, they would likely revert to their own strategy for controlling their vulnerability. Sixteen of our subjects seemed convinced that psychotropic medication and psychotherapy had played significant roles in the control of symptoms and increasing self-awareness. These patients expressed a willingness to consider making one or both of these treatment modalities an essential part of their strategy to reduce vulnerability to recurrent psychosis.

Review of associations between patients' clinical characteristics and their views about the five dimensions suggested some trends relating to specific diagnostic groups. Patients with major depressive disorders with psychotic features appeared more likely to attribute their psychotic episode to a physical illness than did patients with other diagnoses. That group of subjects was also more likely to say that discontinuing medication was an important factor in precipitating the psychotic episode, more likely to value medication in treatment, and more genuinely concerned about vulnerability to relapse than subjects with other diagnoses. Subjects with bipolar disorders showed a marked tendency to minimize their vulnerability to relapse and to minimize the importance of medication in their future treatment. The bipolar subjects also tended more to identify controllable, external factors as the most important precipitants of their illness.

Previous course of illness appeared to have an association with patient views, an association that seemed to hold for all the diagnostic groups. The greater the number of times a patient had been hospitalized, the less likely he or she was to describe his symptoms in detail. Typically, subjects who were hospitalized for the first time discussed their psychotic symptoms extensively, although they might simultaneously say that they were not suffering from a psychiatric illness. Subjects who were hospitalized multiple times were less likely to describe their symptoms, although they often were quite willing to acknowledge that they were ill, and they often identified family problems and conflicts as causal factors in their relhospitalization. Demographic variables did not appear to be associated with patient views about their disorder.

Discussion

It has been possible in this exploratory inquiry into patient views of the psychotic experience to expand the concept of insight and clarify its components. Results of that exploration suggest that traditional descriptive and psychoanalytic concepts of insight into psychotic illness—judging whether the patient is capable of acknowledging he has an illness or the "integration versus sealing over" conceptual model for recovery style—are incomplete and inadequate. The present study suggests that insight might best be viewed as constituted of at least five distinct, apparently largely independent dimensions. The structured interview that has resulted, and the preliminary findings that there may be an association between patterns of insight and the chronicity of the disorder and diagnosis, now provide a more solid basis for learning about the nature of insight and its treatment implications.

This work helps to provide a broader context for considering research on "insight" and its associations. For example, a number of studies several decades ago showed that most psychiatric inpatients did not regard themselves as mentally ill (Joint Commission on Mental Illness and Health 1961; Levinson and Gallagher 1964; Braginsky et al. 1969). A comparative study of U.S. and German mental patients (Townsend 1975a, 1975b) found that a majority of patients in both groups denied they were mentally ill, and 50 percent of both groups felt that they did not belong in the hospital. Our findings suggest that in interpreting such results, it would be essential to consider that only a very narrow inquiry may have been made and to know what
questions were asked and the previous duration of the patients' disorders.

Perhaps the best conceptual model fitting our findings comes from the work of Kleinman (1980) in his cross-cultural study in Taiwan. Kleinman studied health care systems, conceptions of illness and disease, and the explanatory models used by both patients and clinicians. Some of his central concepts include a distinction between disease (the malfunctioning of biological and/or psychological processes) and illness (the psychosocial experience and meaning of perceived disease) and an emphasis on the importance of explanatory models for both clinicians and patients. Kleinman observed that explanatory models are partly conscious and partly outside awareness, and therefore may not be fully coherent and unambiguous. He also noted that the models may change with time and that the doctor-patient relationship can be conceptualized as a transaction between the doctor's and the patient's explanatory models. His analysis determined that an explanatory model for an illness episode consists of the following five major components: (1) etiology; (2) time and mode of onset of symptoms; (3) pathophysiology; (4) course of sickness; and (5) treatment.

As noted earlier, there are increasing attempts to understand and harness the implications of insight that would need to consider the complexities of these phenomena. For example, not all clinicians agree that fostering insight in hospitalized patients is a desirable goal. Indeed, a small number of investigators (e.g., Goffman 1961; Zusman 1973) have hypothesized that attempts to foster insight in psychotic patients are destructive and promote the development of “institutionalization”—acceptance of the sick role with chronic dependence on institutional care. In contrast, some recent efforts in clinical research and treatment have placed increasing emphasis on actively “educating the patient” about his illness, a process that often involves a sustained and active attempt to provide the patient and his or her family members with current scientific evidence and theoretical assumptions about psychosis and its treatment (Seltzer et al. 1980; Hogarty et al. 1986; Brown et al. 1987). In either case the understanding of interventions seems likely to be most accurate and the interventions most helpful if the many aspects of insight are considered and dealt with specifically.

References


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