INSIGHT IS A USEFUL CONSTRUCT IN CLINICAL ASSESSMENTS IF USED WISELY:

RESPONSE TO GUIDRY-GRIMES

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We are grateful for the opportunity to respond to Dr Guidry-Grimes paper on insight[1] and her ethical concerns. We agree that insight is indeed "valuable for patients and thus worth keeping as part of clinical evaluation" and argue that a number of her concerns are ill-founded.

We will show that some of the concerns:

1. are based on a narrow and partial reading of the extensive empirical research and conceptual literature;
2. conflate the ethical challenge of treatment of persons without capacity, in principle (on the one hand) with the basis upon which clinicians judge it necessary to make such decisions on their behalf (on the other); and
3. stem from attributing the cause of sub-optimal care and attitudes to the insight concept rather than other unrelated factors.

THE INSIGHT CONCEPT

Guidry-Grimes states variously that the insight concept is flawed since it is full of "diverging conceptualisations"; that it "idealises human capacities for self-knowledge" ("setting the bar at an unattainable level") … while "minimizing the patient's own perspective". That it is not clear if it is 'static or dynamic' and that studies of associations with insight are 'conflicting' and "relevant facts are in dispute".

Our response could be taken as exemplifying such diverging conceptualisations! However, this would be to gloss over where the true divergence lies. Since concerted empirical research into insight began around 30 years ago[2], the clinical use of the construct has become much more refined and explicit, with deployment of a number of assessment tools with good psychometric properties now in widespread use in research.[3] However, it is true and a cause of frustration that such tools are rarely used in routine clinical or even medico-legal settings, although taking account of the variety of cultural and individual circumstances will always need more open ended and descriptive methods. Divergent views come in when professionals question insight in comparison with other constructs such as decision-making capacity and, more widely, from perspectives within ethics and philosophy (as in the present case) in the context of autonomy, epistemic trust, etc. We would not wish in any way to close down such debates but they must be distinguished from critiques of insight as a phenomenon.

While academics are predisposed to question if not dispute relevant evidence and facts, they can be reassured that a number of systematic reviews and meta-analyses based on dozens of studies and many thousands of participants have been conducted and it is possible to say with confidence that – at least as applied to psychosis – (a) insight is related to psychopathology (worse psychopathology, worse insight[4]) but to an extent that does not render the measurement of insight redundant; (b) there is a reliable association between mood and insight (lower mood, better insight) for various postulated reasons[5]; (c) insight is related to IQ (lower IQ, worse insight) but again the proportion of variance explained by IQ is small suggesting this is only one of several associated factors.[6] There is also a consensus that insight is a powerful predictor of adherence to treatment[7] (even when items related to compliance are omitted from the insight measure in question) and an emerging view that some medium and longer term outcomes are predicted by insight – over and above adherence to treatment.[8 9 10] These are as close to being 'facts' as anything else in the clinical psychiatry.

Our work has shown that insight has both static (trait) and dynamic (state) components.[11] Insight improves with clinical state but patients whose illness is characterised by lower levels of insight across various domains tend to show the same pattern over repeated episodes.[12]

Guidry-Grimes claims that insight requires of patients an unreasonably high degree of self-knowledge. If we go back to Aubrey Lewis[13] he was at pains to alert clinicians that for the patient with a serious mental disorder, "his judgments and attitude can [therefore] never be the same as ours because his data are different, and his machine for judging is different…" p343. Decades of research on reasoning since then (eg[14]) has provided evidence time and again that apparently healthy and intelligent human beings are 'irrational'. Indeed she herself posits a very exacting standard:

"A patient who denies and misunderstands all fundamental facts about their condition cannot provide valid consent for therapies targeted at the condition."

This is narrower than the multidimensional view of insight we espouse and leaves out understanding of the implications of the condition and its treatment which are arguably more salient. Finally, the notion that patients whose insight is being assessed are "best served by regurgitating jargon and phrases heard in therapy" was explicitly rejected in one of the earliest reviews as being 'pseudo-insight'.[15]

USE AND MISUSE OF INSIGHT AND THE BASIS OF INVOLUNTARY TREATMENT

Involuntary treatment legislation in developed countries is usually based on a clinical threshold (a mental disorder of a nature and degree…) as in the UK and/or on demonstration of a lack of decision-making capacity regarding healthcare. Subsequent to lack of capacity being demonstrated, based on a clinical assessment and according to explicit legal criteria, decisions are made in the patient's best interests. While there is much necessary ethical and legal debate around such processes, questions of insight play no formal part.

Guidry-Grimes states: "A poor/partial insight designation should not, *on its own* [italics in original] justify coercive tactics". We whole heartedly agree yet know of no situation where this pertains.

And again: "If a patient is assessed to have poor insight and poor capacity by extension… they could lose authority to make decisions." Insight does not figure as an explicit legal criterion in any assessments of capacity that we know of, although the two constructs do correlate significantly particularly in people with psychosis.[16]

It seems that Guidry-Grimes is uneasy about the whole 'high stakes' business of involuntary treatment in people with serious mental disorder, the use of long-acting injections and so forth. This is a position shared by many but should be debated with the alternatives, on their merits. True it has been suggested before that some clinicians may use terms like 'lack of insight' or single word descriptions (e.g. 'poor')[17] loosely and as a shorthand to convey lack of capacity particularly around treatment or the severity and intractability of delusional beliefs, in medico-legal situations. But this is not the fault intrinsic to the insight concept which, to those of us engaged in research around it, is rich and 'fine grained'; Guidry-Grimes and others' critiques do however prompt more attention as to how it is used in practice. Similarly, to misuse categories of ethnicity, ageing, social class etc., as a way of avoiding proper consideration of individual mental health needs and desires but instead to reach prejudged positions, is to be deplored. Saying a person is incapable of some occupation simply because they are deemed 'too old' would be wrong. But it should not preclude the proper consideration of 'age' as a genuinely worthwhile topic from cultural, sociological or biological points of view.

In any event, contrary to Guidry-Grimes assertion, we have recently reviewed the scientific literature on whether insight is tied to 'protected characteristics' under the UK Equality Act (2010), such as

race, ethnicity and gender. We found no evidence of strong associations with any demographic variable (available from the authors on request). We raise with concern that a small association was found when comparing white with black patients, which adds a novel contribution to this debate and warrants further inquiry. However, it is also notable that racial differences in insight were far weaker than in diagnosis of psychosis and involuntary psychiatric treatment and may be in line with differences found with capacity to consent to treatment. Neither should this result be interpreted without reference to intersections with wider inequalities.

RECOMMENDATIONS

In view of the concerns that have been raised, we highlight existing practice guidance. In England and Wales, anyone who conducts a capacity assessment should follow the principles of the Mental Capacity Act (2005). For our purposes, it is especially relevant that they must: a) presume that the person has capacity, b) assess capacity only in relation to a specific decision, c) establish a link between the diagnosis and functional inability in question, and d) consider the person's will and preference for any decision made in their best interests. Guidry-Grimes provides an anecdotal example (p. 180) in which the physician had clearly overlooked these criteria whilst using insight as evidence. As stated in the recent UK National Institute of Health and Care Excellence (NICE) guideline[18], "If a practitioner believes a person's insight/lack of insight is relevant to their assessment of the person's capacity, they must clearly record what they mean by insight/lack of insight in this context and how they believe it affects/does not affect the person's capacity." (NICE, 2019). We endorse these recommendations.

Finally, we would urge critics like Guidry-Grimes to look beyond the caricatured view of insight as a summary judgement by someone in authority over another and instead consider insight in more intrapersonal terms. Insight is another word for self-knowledge and it may even have a dedicated brain system for its implementation.[19 20] It is more about a conversation we have with ourselves about what we truly believe than the opinion of others. Acknowledging that one is ill or impaired or in need of help is never easy but, we contend, it is necessary for living an authentic life.

Acknowledgements

The authors are grateful for the comments and contribution of Gareth Owen and Wayne Martin.

Funding

The work arises out of the Mental Health and Justice programme funded by the Wellcome Trust. ASD is also supported by the UCLH National Institute of Health Research Biomedical Research Centre.

Competing interests

None

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