

The Issue of Insight

by Larry Davidson, Ph.D.

- But what about people who won't accept having a mental illness?
- How can a person recover if he or she won't even acknowledge being ill?
- How is recovery relevant for people who say there is nothing wrong with them?
- But what about people who won't accept any treatment, who deny they need any help?
How does recovery-oriented care apply to them?

These questions—and others like them—are frequently posed by frustrated practitioners and distressed family members trying to assist people who appear not to want help. One concern, or assumption, about these questions is that they point to a key limitation of the recovery paradigm, implying recovery and recovery-oriented practices are only for people who readily acknowledge having a mental illness. After all, how can a person be "in recovery" if he or she has nothing to recover from? One of the major differences between mental illnesses and other medical conditions is the issue of insight. People with diabetes know they have diabetes; people with asthma know they have asthma, etc., but some will argue that most people with serious mental illnesses (or at least those with schizophrenia) lack insight into having the illness. Therefore, they will not participate in the treatments needed to manage their conditions. Such perceptions lead some people to argue that coercion and involuntary treatments are necessary, at least for those who refuse any or all treatments. The lack of insight also poses a major challenge to person-centered care planning and recovery-oriented practice, if both presume the person will take responsibility for driving his or her own care and overall recovery process. Is not insight, therefore, required for recovery?

While it may sound contradictory at this point, I intend to show in the following two sections not only that recovery-oriented practice is possible for people who appear to lack insight, but that it may also be precisely these people who **most** need recovery-oriented care. Presently, people who appear to lack insight in these ways either receive no treatment—because they choose not to access care—or receive treatment in ways that to varying degrees are against their will. We do not consider either situation ideal within the context of recovery-oriented practice, and therefore argue it is perhaps these people—more than any others—who are in dire need of the constructive and effective alternative offered by recovery-oriented practice. How this is possible will take some explanation, because the question of insight or acceptance is a complicated one with several different answers.

When Insight Is Lacking

A first question for clarification is "insight into what?" Is it necessary for a person to accept he or she has a serious mental illness that we describe as "schizophrenia" or "psychosis" in order to participate in and benefit from person-centered care? Or is it enough that the person is aware and willing to acknowledge something has gone dreadfully wrong in his or her life and might benefit from assistance trying to set things right? Many of those who either do not believe or choose not to disclose having a mental illness to others for a variety of reasons, including the fact that many people continue to associate mental illnesses with serial killers, axe murderers, or Jekyll-and-Hyde behavior changes, will still agree their current lives do not measure up to what they had wished for. If they concede their lives could be improved in some small way, there is room and

opportunity for person-centered care. (As long, of course, as this care does not require the person to accept or acknowledge beliefs about him or herself that he or she denies). In other words, we can offer different forms of help, including medications, to people who do not accept or acknowledge having a mental illness—if that help does not come with too many strings attached **and** is viewed by the person as useful in his or her efforts to have a better life. As an example, a person who acknowledges staying up all night but denies auditory hallucinations are keeping her up, may still agree to try a medication that could help her get a good night's sleep (even if the mechanism by which the medication works is to quiet the voices).

A second clarification is to consider if the issue of insight is present both in and between acute episodes of illness. People suffering from depression may be too depressed to recognize they are depressed; people experiencing an acute manic episode may be too manic to recognize they are manic; and people in an acute episode of schizophrenia may be too disorganized, paranoid, or absorbed in hallucinations and delusions to step back and recognize they are acutely symptomatic. This unawareness may no longer hold true, however, after the acute episode. Even in the case of schizophrenia, an illness for which the lack of insight has been proposed for more than a century as a pathognomonic sign, I have yet to meet someone with the condition who was unaware that something had gone dreadfully wrong in his or her life. The person's account of what went awry may differ significantly from ours, but he or she is nonetheless painfully aware there is a significant problem and, more importantly, that others' help could be beneficial, **should these others be trustworthy people who have proven to have the person's interests at heart.** As long as the person is willing to accept such help, person-centered care planning and recovery-oriented care remain possible.

But why do so many people with serious mental illnesses appear not to have insight? This may be because they are in the throes of an acute episode. It may be because they are being encountered within a clinical setting where they feel scrutinized or devalued, and where acknowledgement of their problems would be perceived as a concession that could things worse. If you are stopped by the police for speeding, for example, you would not want them to know you didn't have your seatbelt fastened (a personal story, and an extra \$37 ticket), or worse yet, that you have cocaine stashed in your glove compartment (not a personal story). They may appear not to have insight because no one has had or taken the time to earn their trust and provide a context within which they could feel comfortable sharing their most intimate and painful secrets. Put more simply, they may appear not to have insight because their personal explanation of their predicament differs significantly from that of the mental health staff offering treatment. This is such a common problem that it deserves a few paragraphs of its own.

After all, if lack of awareness of the illness is not an essential characteristic of schizophrenia (it has yet to be accepted as such after a century of debate), why is it so difficult for people with the condition to accept they have it? It is interesting to note that during the era in which lack of insight was first identified in schizophrenia, people were never told they had schizophrenia, or any other mental illness for that matter. As recently as 25 years ago, it was still considered taboo to inform people with serious mental illnesses that this was what we thought they had and what was causing their problems. If we did not view people with mental illnesses as capable of digesting and using such information, and therefore did not educate them, how could we expect them to "accept" their diagnoses?

Even if we did educate people in school and in the general public about the nature of serious mental illnesses—as some particularly progressive countries have started to do—it is far from a straightforward matter. The picture of what constitutes "schizophrenia," for example, has only become more complicated since the term was first introduced by Bleuler at the beginning of the 20th century. As deliberations continue for the drafting of DSM-5, many scientists are arguing there is simply no unitary condition we can call "schizophrenia." There may be a group of loosely related conditions we might call "the schizophrenias" (as Bleuler had originally thought), or there may be independent conditions we have mistakenly lumped together because of a Wittgensteinian "family resemblance," with the now well-established heterogeneity in course and outcome due to the fact that these are actually different conditions. Finally, the psychiatric community in Japan has decided to do away with the term schizophrenia altogether, having found it stigmatizes and compounds complexities associated with diagnosing serious mental illnesses. If, after a century of dedicated clinical investigation, the field of psychiatry cannot agree on what constitutes the condition we have described as schizophrenia, why should we be surprised some people are so skeptical and unwilling to accept the diagnosis, especially when we have insisted for so long on designating them as "schizophrenics" rather than people experiencing a condition we call schizophrenia?

As the consumer movement has now made abundantly clear, no one should be expected to accept being "a schizophrenic." This is simply not the same as being "a diabetic" or "an asthmatic," given the history of the term and the associated stigma. Providers who attempt to offer person-centered care to people they view as "schizophrenics" will be doomed from the start, not because of the deficits imposed by the illness, but because of their failure to respect the people they serve. In our experience, accepting diagnoses such as psychosis, schizophrenia, and bipolar disorder is not a prerequisite for participating in person-centered care. The only prerequisites for participating in this type of care are the desire to improve one's life and the willingness to determine whether other people can play a useful role assisting the person to make his or her life better. If these conditions are in place, we can enter into productive discussions about how to make the person's life better and what each party can contribute.

But how can you have such discussions without using the same diagnostic terms these people reject? How can you develop a person-centered care plan for a person with schizophrenia without basing the plan on the fact that the person has schizophrenia? This central question cuts to the core of what is new and exciting about recovery-oriented practice. Many practitioners will begrudgingly acknowledge that diagnostic labels are used mostly for the benefit of insurance companies or Medicaid/Medicare to justify reimbursement. While this is an oversimplification, i.e., there are other legitimate uses for making as accurate a diagnosis as possible (given the current state of our science), this common complaint suggests diagnoses are not all that helpful in formulating care plans on an everyday, "real world" basis. What is more important for the care-planning process—and, as it turns out, what is more important to the person him or herself—are the ways in which what we describe as schizophrenia or bipolar disorder impact the person's day-to-day life and make life more difficult than it would be otherwise (all other things being equal). Person-centered care plans are based on the person's aspirations and life goals and the ways in which pursuing these goals and aspirations have become difficult—not on his or her diagnosis.

This is not to suggest we ignore the mental illness or pretend it is not actively disrupting the person's life. Rather, those elements of a person's experience caused by serious mental illness can be framed as barriers or obstacles the person faces pursuing his or her goals, or simply things that interfere with the person having the kind of life he or she wants. While it may seem to make little sense to describe the mental health condition of schizophrenia as a "barrier," in the person's experience aspects of the illness that are distressing and/or disruptive are more important and more pressing for attention than any particular diagnostic label or the etiological explanation that a diagnosis is supposed to convey, e.g., "you are hearing voices/having paranoid thoughts because you have a condition we call schizophrenia." We suggest it is this mismatch between people's lived experiences of the condition and our current diagnostic labels that accounts for a significant degree of the problem of insight with which we began.

Consider medical examples such as the fever that accompanies an infection or the flu. We know when we feel hotter than usual and have learned over time that a fever might indicate any number of medical conditions. When a doctor or nurse tells us we have a fever, we are therefore not usually surprised and have come to expect that various courses of treatment might be tried depending on the fever's cause. If a bacterial source is suspected, we are prescribed antibiotics and may be told the medication could be ineffective if the cause turns out to be viral. Either way, we are told to expect the fever will go away in a few days and, if it does not, to contact the health care provider again.

Now consider the example of a psychotic episode. The first time a person has such an episode, he or she is not likely to know that it is in fact psychosis. For most people, the initial experiences of hallucinations, delusional beliefs, and difficulties in thinking do not resemble other medical symptoms, and typically there has been little in the person's family or educational background that could prepare him or her to identify these experiences as symptoms (i.e., unless a close relative has had a mental illness). In addition, these experiences are usually quite compelling and difficult to ignore, at times even arguing for a certain explanation of their presence (e.g., voices telling the person he or she is involved in a CIA thought experiment). Such compelling and distressing experiences do not go away when the person is told they stem from an underlying mental illness. Unfortunately, there has been little more offered by way of explanation to persuade the person that the diagnosis accounts for these experiences.

When pushed, practitioners have resorted to explanations such as "you have a chemical imbalance in the brain," "your neurons have an over/under-sensitivity to dopamine," or "your brain is playing tricks on you." But there is little in such an explanation that helps a person understand why the voices are addressing him personally; why the voices know so much about him and his concerns; why the voices are so harsh, critical, or disruptive; why he can no longer carry on a coherent conversation; or why he feels so unsafe that it seems the pope or the mafia (or whomever) is trying to hurt him. Why, if my neurons are firing so haphazardly or misfiring accidentally, do these experiences suggest a very different, very non-haphazard story? Psychosis is no more unstructured or chaotic than dreams. Diagnostic categories like schizophrenia and bipolar disorder come across as relatively abstract and empty concepts in attempting to account for what are very real and compelling experiences.

As a result, it is often more effective when talking with people who do not simply accept having

a mental illness to focus on the aspects of the condition the person finds most distressing and disruptive and to remain at that level. For example, it is possible to say to someone, "It seems like you are being harassed by voices and feel unsafe a lot of the time," without taking the extra step of concluding "and those experiences are part of a serious mental illness called schizophrenia." It is possible to stop after commenting on how unsafe the person feels and ask, "How do you think I can be of help to you?", "What might help you feel safer?", or "What has helped you feel safer when you've had these kinds of experiences before?" And it is possible to suggest medications or other interventions that might be helpful in addressing these anomalous experiences without necessarily labeling them as "psychotic." It is possible, for example, to say you have known other people with similar experiences, and some things they found helpful were certain medications and coping strategies (e.g., negotiating with voices). In other words, it may be more effective to remain within the person's frame of reference as much as possible and bring new information into that frame that might be useful in addressing the person's immediate and pressing concerns, rather than asking him or her to take a leap of faith to believe in the utility of a diagnostic label that remains far from his or her experience base.

Once again, it is important to note this does not require the practitioner to ignore or downplay the illness, much less pretend the person is not ill. Rather, we are suggesting a strategy for connecting to and engaging a person in a potentially helpful (and even healing) relationship based on the person's understanding of his or her predicament—what psychotherapists and outreach workers have described as meeting the person where he or she is at rather than requiring the person to meet us on our terms (and often turf). As a fundamental principle of recovery-oriented practice, this strategy is perhaps most needed by people who have not found a traditional biomedical explanation of their experiences to be either helpful or palatable. In this case, the suggestion of meeting the person where he or she is at might need to be taken both literally and metaphorically. That is, as many such people refuse to attend appointments at clinics or mental health centers, and often will have little to do with practitioners who identify themselves as mental health staff, connecting to them can require concerted and consistent outreach beyond the walls of conventional mental health settings.

Conducting this kind of outreach to engage people in trusting relationships may also be one of these practice areas for which peer staff may be especially, if not uniquely, qualified. Who better to connect to someone hearing distressing voices than a person who has heard them him or herself? Who better to engage someone who is untrusting than an individual who has also felt unsafe? Who better to translate medical and psychiatric knowledge into the language of everyday experience, to build bridges between the mental health frame of reference and the person's frame of reference, than someone who has experienced both?

Meeting People 'Where They Are At'

Other than offering access to peer support, how can practitioners offer recovery-oriented care to people who do not accept or acknowledge having a mental illness? First, by **not** insisting on acceptance or acknowledgment of having a mental illness as a precondition to providing concrete and practical assistance with **their concerns**. Second, by finding out what those everyday concerns and needs are (by meeting the person where he or she is at) and offering concrete and practical assistance to address those concerns and meet those needs. (The Housing First model developed by Tsemberis and colleagues provides an excellent example of how highly effective

such an approach can be for engaging and supporting people with mental illnesses, without setting preconditions on the help offered.) Third, by taking a strength-based (as opposed to an illness-based) approach to addressing the identified concerns and needs. And fourth, both for the person in need and the practitioner's sake, it is important to understand the engagement process will likely take time before producing tangible results.

If a person has been living with an unacknowledged and untreated serious mental illness for any length of time, he or she is likely to have developed some sense of reality that provides at least some sense of order in his or her life and some degree of protection against external threats, such as those posed by the police, intrusive mental health staff, and caring family members. If it has taken months or even years to build up such a structure, it is likely to take months or years for the person to begin questioning or putting this structure aside, even temporarily, to allow another person in. Keeping a sense of perspective in terms of the longitudinal course of the condition over the person's lifetime is essential to persisting in the efforts described below.

There will be times, for example, when people will insist they do not need help of any kind and have no concerns or needs for which another person's assistance or support is required. They are just fine, thank you very much, and have no need for your services, no matter how those services are described or offered. Prior to throwing in the towel in such cases, practitioners may need to consider alternative routes to engagement. A key question in this instance, as it often is within the framework of recovery-oriented practice, is **how is this person spending his or her time?** In the spirit of meeting the person where he or she is at, it is important to consider this question from the person's perspective rather than (or at least in addition to) the practitioner or family member's perspective. That is, while it may appear to you or the person's loved ones that all he or she is doing is watching television or sleeping and smoking cigarettes, the person is likely to have a different perspective. And often it is the person's perspective, rather than the concern the person is doing nothing, that offers the point of departure for engagement. Seldom, if ever, is a person doing absolutely nothing. If the person appears to be doing absolutely nothing and does not offer an alternative account of how he or she is spending the day, then consider Pat Deegan's eloquent plea for understanding the reality that often lies beneath or behind such appearances:

The professionals called it apathy and lack of motivation. They blamed it on our illness. But they don't understand that giving up is a highly motivated and goal-directed behavior. For us, giving up was a way of surviving. Giving up, refusing to hope, not trying, not caring: all of these were ways of trying to protect the last fragile traces of our spirit and our selfhood from undergoing another crushing (Deegan, 1994).

How can we use any information the person is willing to provide about his or her time, while being careful not to represent the latest "crushing" in that person's life? The first two answers to this question reflect basic premises of recovery-oriented practice: 1) in the absence of information to the contrary, assume the person wants the same kind of things out of life as everyone else, and 2) build on strengths.

Take, for example, the story of Hank, a 47-year-old man diagnosed with schizophrenia and a developmental disability. Hank lived at a board and care home and both the staff and his sister complained to the mental health clinic where he received medication management services that

he had nothing to do with his time except smoke cigarettes in the yard. This had become a pressing problem for the board and care home and Hank's sister because he was harassing other residents for cigarettes and pestering her for additional money. He insisted there was nothing else for him to do during the day and did not see his behavior was problematic for others. However, if the situation was left unaddressed, he was at risk of being thrown out of the board and care home where he was living. Hank's sister was already worried about finding another place for him. Being somewhat gregarious, however, Hank was quite willing to talk to an outreach worker, especially when he learned she was a young female. Over the next several weeks, the outreach worker visited Hank at the board and care home and explored his interests. When asked if he was interested in a job, for instance, Hank responded he didn't need the money because he had cut a number-one hit record and his royalty check was due any day. Once the check arrived, he would pay the other residents and his sister back for all the cigarettes and money he had borrowed and thereafter live on "Easy Street."

It wasn't until sometime into the second month of her visits that the outreach worker stumbled upon another of Hank's interests. When asked about the things he used to do for fun, Hank said he had a longstanding interest in cars. As a teenager, when other boys his age were getting learners' permits and dreaming of their own cars, Hank was busy building models of antique and sports cars. Shortly after this discussion, the outreach worker asked Hank if he would like to build model cars again, for old times' sake. Hank liked the idea, but bemoaned not having the money to buy the kits right then, since his check had yet to come and he didn't even have enough money for cigarettes, let alone model cars. With Hank's permission, the outreach worker contacted his sister, who was more than happy to provide him with a gift card to a local hobby and craft store as an early birthday present. The outreach worker and Hank visited the store together, and Hank selected a couple of models, glue, and other supplies he would need.

Several months later, the outreach worker was happy to see the models completed and displayed proudly in Hank's room, and surprised to learn he had secured a part-time job at an auto mechanic shop down the road. With his interest in cars piqued, Hank had begun taking 10-minute walks to the auto shop to look at cars and chat with the mechanics. After several weeks, the owner offered to pay him to wash and dry cars he had repaired so they would look nice for their owners. Hank started working about 8 hours a week for minimum wage, which provided a little disposable income on top of his disability allowance. Just as importantly, it gave him a more concrete sense of belonging within the automotive world. At this point, the outreach worker decided not to ask Hank about his change of heart in terms of work, satisfied to notice he no longer mentioned his number-one hit record or imminent royalty check.

Felicia's story offers another example. While Hank had been willing to take antipsychotic medication and visit the clinic every few months, Felicia adamantly and consistently refused all mental health services. She lived with her parents, who were increasingly concerned about her refusal of any assistance or support, and saw her becoming more absorbed in a world of hallucinated voices and paranoid and delusional beliefs. In particular, Felicia's parents were very concerned about the walks she would take in the middle of the night when she couldn't sleep, often slipping out of the house between 2 and 4 a.m. to wander around town in the dark. Felicia would not listen to their protestations or concerns. She dismissed the thought she might be robbed or raped, and stubbornly insisted she had the right to be out at any hour of the day or

night. While Felicia insisted she needed to walk outside at those early hours for her health, her parents could not reconcile her paranoid thoughts with her apparent willingness to put herself at risk for victimization. What they did not know until much later was the voices Felicia had been hearing at night insisted she leave or else death and destruction would be brought upon the house, killing her and her parents. From this perspective, it became apparent Felicia's nighttime walks were driven both by her fear of the voices and her courage and determination to save her parents from the hell she was experiencing.

Felicia's parents became very frustrated with the local mental health agency's consistent response that there was nothing they could do to intervene unless she posed a serious risk to herself or others, or became so gravely disabled that she was not able to take care of herself. According to the agency's staff, the risks posed by her late-night walks were not considered serious or imminent enough to justify coercive or involuntary measures.

Not knowing where else to turn, Felicia's parents attended a local National Alliance on Mental Illness chapter meeting, where they learned of a nearby peer-operated drop-in center that might offer them some hope. They visited the center and explained their situation to the peer staff. At first, the staff echoed the response of the mental health agency, informing them there was nothing they could do if Felicia was not willing to come to the center of her own accord. Rather than citing State statutes regarding risk, their reasoning was that drop-in centers were strictly voluntary programs and they thought it was important to respect Felicia's wishes and autonomy. They would not be comfortable doing anything she had not agreed to beforehand, including visiting Felicia at her home as her parents had requested. Not to be swayed in the face of even the most formidable obstacles, Felicia's parents asked if they could speak to someone at the center who might be particularly sympathetic about their situation. Wasn't there anyone, either staff or a member, who had once been in Felicia's shoes and could offer some useful advice?

The center staff made note of the request and promised to call them if they found someone who fit their description. Several days later, Felicia's increasingly skeptical and concerned parents were relieved to get a call from the drop-in center. They had presented the request at a staff meeting, where a staff member had agreed to talk further with Felicia's parents about her previous experiences. She called them and explained she had also been very reluctant to accept mental health services, or any help for that matter, in the early course of her mental illness, and understood their concerns and frustration. While she felt it was important to respect Felicia's wishes, she was happy to visit them to discuss the situation and meet Felicia if she was willing. Several days later, the staff member visited Felicia's home to meet with her parents. She told them her story of recovery and how difficult it had been for her and her family to struggle through the darkest and scariest days. She encouraged Felicia's family not to give up hope and continue to "be there" for Felicia despite her challenging behavior. Although she had not personally taken the risks associated with Felicia's late-night walks, she had experienced significant difficulty sleeping through the night—a problem she still struggled with. She was also often awake between 2 and 4 a.m., but had found ways to manage this disruption without putting herself in a risky situation. At that point, Felicia's father jokingly suggested the staff member could talk with Felicia at 3 a.m., since they were both awake at that time and had little else to do.

The staff member laughed politely at the suggestion, but then paused and wondered aloud, "Why

not?" As it turned out, she worked the night shift at the respite program operated by the drop-in center and was happy to talk with Felicia at 3 a.m.—once again, if Felicia was interested. Excited by the idea, Felicia's mother called up to her bedroom and asked if she would be interested in meeting another "night owl." Curious about what her mother meant, she came downstairs to meet the staff member, who introduced herself as another person who was often awake between 2 and 4 a.m., and who would be happy to have some company during that time. At first disbelieving, Felicia was about to return to her bedroom when the staff member offered a piece of paper with two phone numbers. "If you don't believe me," she said, "call either or both of those numbers any night you want and see if I'm up, too. Chances are I will be."

To which Felicia responded, "But why are there two numbers?"

"Oh," the staff member replied. "The second number is my home number, but several nights a week I work the night shift at a respite program and that's the first number. I figured if I was going to be up anyway, I might as well get paid for it."

A week or so went by before anything happened, but soon after, Felicia called the first number on the paper. She was pleasantly surprised when the staff member answered the phone and seemed genuinely glad she had finally called. Over a series of months, a trusting relationship gradually developed between the two. The first indication of any real "progress" from Felicia's parents' point of view came about 6 months into the process, when Felicia agreed to take a self-defense class with the staff member at a local YWCA. As they progressed through the class together, Felicia's self-confidence began to grow, and their late-night conversations deepened. Felicia finally explained why she had difficulty sleeping through the night and what the voices were saying when they threatened her. Much to her surprise, the staff member did not find the explanation strange, nor did she view Felicia as "crazy," as many of her former female friends from high school had. Instead, she seemed familiar with the experience of hearing voices and actually had some useful strategies to make the voices less distressing. She also suggested Felicia stop by the drop-in center during the day, when other people who heard voices could talk with her and compare notes. Felicia was intrigued by this idea and agreed to stop by on a day the staff member could introduce her.

After hearing from several members of the drop-in center that certain medications might also help decrease or control the voices, Felicia decided to make an appointment with her primary care doctor. After she made it perfectly clear she had no interest in visiting the local mental health center to see a psychiatrist, her doctor prescribed a low-dose antipsychotic medicine to see if she would benefit. It took several visits over several months to find the right medication at the right dose, but Felicia eventually experienced significant relief from the voices and paranoid ideas and became a regular member of the drop-in center. Where she will go from here has yet to be determined, by her.

As these examples suggest, cultivating a trusting relationship within which the person may eventually begin to divulge his or her concerns and become willing to accept support takes time and persistence. For some people, however, there may be no way to promote recovery and no shortcuts, other than to be willing to take the time required.

Conclusion

Until now, it has primarily been staff on outreach or assertive community treatment teams who have had to learn how to "observe the proper rites" in "establishing ties" with people who have refused mental health care. As the behavioral health field moves more firmly and deeply into the territory of recovery-oriented practice and we strive to meet our patients or clients where they are at, the lessons these staff have learned will become relevant and useful for staff in a variety of settings, so clients can benefit from the full range of services and supports we have to offer.

Reference

Pat Deegan. 1994. A Letter to My Friend Who Is Giving Up. *The Journal of the California Alliance for the Mentally Ill*, 5, 18–20.

Insight, by Gina Duncan, M.D.

Assistant Professor in the Department of Psychiatry and Health Behavior at Georgia Health Sciences University.

As defined within the context of psychiatry, insight is the ability to recognize that one has a mental illness or is experiencing symptoms of mental illness.¹

Working with someone who appears to lack insight into having a mental illness—a person who denies or refuses to acknowledge the condition—is often among the most difficult issues facing mental health care providers and loved ones. When speaking in the community, one of the most frequent questions I receive is how to help a loved one realize he or she could benefit from treatment. The challenge may seem daunting, but it remains incumbent on us as providers to cultivate insight by reaching out to people who are suffering and disengaged from care.

A pertinent question, however, is *insight into what?*

A deficit-oriented approach would focus on a person's recognition and acceptance of a diagnostic label such as schizophrenia; acceptance of the fact that he or she has an illness; and acceptance of the limitations this illness might impose, i.e., accepting there will be things he or she cannot have, do, or achieve as a result. A recovery-oriented approach seeks to foster insight into the *possibilities* as well as the challenges associated with mental illness.

Not having reliable research data or a crystal ball to predict the long-term outcome of a person's illness (there is tremendous heterogeneity of outcomes for these disorders), it is best to stay away from definitive pronouncements about what a person will or won't be able to have or do in the future. When trying to help someone accept the reality of having a mental illness, suggestions for how to approach the situation and person are included below.

Start with the individual's understanding of the situation. This does not mean the practitioner should ignore or downplay the illness, but recognize that trying to force someone to identify with a diagnostic label he or she rejects is likely to be unproductive and lead to an impasse. This is especially true in the case of diagnostic labels that have been stigmatized by society for centuries, some that are associated with discrimination and suggest to people they have lost their minds or are dangerous. A very common and understandable response to being told one has an illness called "schizophrenia," for example, is for the person to protest that he or she is not a serial killer or doesn't have a "split personality."

Rather than fighting such a lose-lose battle, find out what is meaningful for the person and connect with the goals he or she wants to achieve. What dictates a meaningful life is subjective and unique to each individual, whether the person has a mental illness or not. If we are to help promote significant growth in another person, we must be cognizant of and sensitive to this. What are the individual's unique life goals? What would he or she want life to look like if all current challenges could be magically erased?

Without judgment, positively affirm any goals the person has that would be constructive to pursue. Your own opinion of how realistic the goal is (for example, getting a Ph.D. if the person has yet to complete high school) is not nearly as important as the fact that this individual has a

goal he or she is willing to work toward. This offers the two of you a basis for discussing what would help the person progress toward the goal (e.g., a first step might be getting a GED).

Avoid diagnostic labels or terms. Instead, describe elements of the individual's life (over which he or she has some control) that conflict with his or her expressed life goals. Then elicit the person's observations and sense of whether these things are perceived as personally problematic. For example, "You said your goal is to have a job so you can leave the group home and support yourself independently, but as I see it, staying in bed all day and drinking are actively working against that goal. What do you think?"

Find the person's "buy-in." What aspects or byproducts of the illness can you both agree are problematic? Even if the person rejects the diagnosis, he or she may still be able to agree that a painful byproduct of the current situation has been fractured family relationships or job loss. Once these issues are identified as problematic, the two of you can begin to explore ways to improve them.

Inspire hopefulness by highlighting past successes and available strengths and resources. Rather than focusing on limitations, help the person develop insight into what it will take to achieve a specific goal, using past successes as examples. Specifically noting how treatment can aid in this process could also be helpful. If the goal is to have a job, you might point out that when the person took medication in the past, he or she was able to get adequate sleep and had the energy to work and concentrate.

Engage in a discussion about what needs to happen for the person to reach his or her goals. For some people, this might take a long time and the process may stall after you state your concerns. However, do not let this deter you from returning to the discussion on future occasions. You never know when a turning point might present itself. For the person who *is* ready to engage in this discussion, focus on hopeful and realistic steps. In the above example of an individual with no high school diploma interested in pursuing a doctorate, this means finding resources to connect the person with a GED course.

Be mindful that what concerns you in terms of a person's experience of symptoms may not be significantly concerning to him or her, and accept that what is meaningful to you may not be meaningful to someone else. For example, if the individual's voices have a special spiritual meaning, he or she may not agree the voices are hallucinations that should be treated with medication. Similarly, someone who feels artistic creativity is dampened by medication may choose not to take it. For that person, the ability to creatively express him or herself may be more important than not hearing voices, holding a job, or experiencing other side effects.

As providers, we all too often focus on the complete eradication of symptoms, to the point of excluding other elements of well-being. But it is critical to remember recovery can occur *in* the illness, not just *from* the illness—something both the person and the practitioner should know.

Do we seek to foster insight into limitations or possibilities? Regardless of a person's level of impairment, we can strive to offer insight into the possibilities of a meaningful life.