“My Doctor is Lacking Insight”: Alternative Experiences of Insight in Mental Health

from Psychiatry is Driving Me Mad (Blog)
by Wren Aves, May 7, 2022

[Content Warning: Discussion of suicidal ideation and iatrogenic harm]

When I was a teenager, I told my friend I was thinking of killing myself. We were walking down the street and I just came out with it. My friend stopped walking and just stood still, unsure what to do or say. It was clear he was frightened by what I had said. Without much warning, he promptly pushed me into the canal. It was winter, so the water was absolutely freezing, and I plunged fully under the surface, in all my clothes. The shock made me gasp and breathe in water. I managed to pull myself out relatively quickly, and much to the amusement of the primary school children in the playground next to us, I immediately shoved my friend into the water. We both ended up sitting on a bench, freezing cold, coughing, laughing, and making sure neither of us were injured, or had destroyed the things in our pockets… and then we talked. It was an open, honest conversation, from both sides, and my friend acknowledged that he had pushed me into the canal because he was frightened and hoped in some strange way the shock would fix me. It was less about my wellbeing and more about him wanting to feel secure again. To this day, that exchange was more sincere, more caring, and more helpful than any I have ever had with a healthcare professional.

I have been thinking a lot about this recently, particularly in relation to how people’s responses to someone in pain are often due to their own feelings and their own need to feel safe. When we support others in pain, having insight into why certain thoughts and feelings may arise is so important, or we risk causing more pain and harming those we intend to help.

Insight in mental health is pretty much exclusively thought of as the insight or lack of insight in people with mental health difficulties and how this affects our health and engagement with services. For patients, insight is an annoyingly slippery concept, frequently wielded as a double-edged sword which can cut you down no matter which side of it you lie. For professionals, however, not only do they seem immune to the consideration of their own insight, but their lack of insight can be used as proof of our pathology. Rarely when someone discusses mental health and insight do we think about insight in mental health professionals, and how their insight (or lack thereof) massively impacts on people’s care, experience of services, and clinical outcomes.

“Insight” in patients is conceptualised and utilised in a number of ways. In mental health terms, insight could be considered more of a philosophical than medical construct, regarding the awareness of an individual of their personal situation, their health status, their understanding of reality, and whether or not they accept their diagnosis/status as mentally ill. A lack of insight as it is understood here can be applied to anyone and any diagnosis but is most frequently considered in people who experience psychosis.

In practice, clinicians can have a black and white view of insight (no insight: very unwell - insight: not unwell), with those lacking insight often experiencing coercive and restrictive interventions, while those felt to have full insight commonly denied care on this basis. I am usually in the latter group of patients, described as having good insight into my own health. Unfortunately, this declaration is not helpful to me, rather it’s code for “if she is suicidal, she is free to go ahead and end her life”. “Insight” into my health is also very frequently confused with how well I am. Being able to flatly and calmly explain to a clinician that I am going to kill myself or I’m hearing distressing voices, and then explain all the reasons around it and the things I have tried to do to help myself ends with a letter which says I have insight into my current situation and as such am not high risk and require no help. While lacking insight can be extremely frightening and may lead to high-risk situations, this fact does not negate the risk or seriousness of the distress of someone perceived to have insight. Alongside this, insight is sometimes used interchangeably with mental capacity, they are not the same. Mental capacity in medicine is a legal construct with very specific directions in the Mental Capacity Act, and its corresponding code of practice, on how to understand and assess someone’s ability to give or withhold consent or make specific decisions about their life. While lacking insight is likely to affect an individual’s ability to make a capacitous decision, they are not the same thing, and lack of insight is not included in the legal assessment of capacity.

Insight can also be used as code for quietly complying/agreeing with the clinician. I have been praised for my insight when agreeing with clinicians, and immediately castigated with “lacking insight” when I have disagreed. Insight in this context is nothing to do with the individual, their mental state, or their actual insight into their health, it is usually about convenience or clinical arrogance. The patient doesn’t agree, while the clinician feels they are absolutely correct and aren’t willing to compromise or even spend the time trying to further explain their reasoning. In this context the ego of the clinician is revealed as they measure their patient’s insight against their own understanding of the world. The importance of this should not be overlooked. By using their own personal subjective understanding of reality as a yard stick for everyone else’s insight, the clinician is anointing themselves with some kind of ultimate power of insight – like a god. The person before them is literally mad because they do not agree with them. This can become difficult for people who disagree with mental health clinicians over the validity or suitability of their diagnosis, for example, people who contest a diagnosis on the grounds that they believe the construct invalid, could be considered

lacking insight into their situation, because they are unwilling to simply agree with the clinician.

Given that the clinician-patient relationship is central to mental health care, insight into yourself as a professional would seem an absolute necessity for effective, compassionate practice. While I have seen professional discussions around confronting internalised prejudice and discriminatory beliefs, such as racism, sexism, and homophobia, there is much less of a conversation around confronting other prejudices, such as transphobia, biphobia, misogyny, classism, and ableism. Further to this, it seems a startlingly high number of mental health clinicians do not have routine supervision to help them work through the emotional difficulties they confront at work, or in-house "team formulations" are used in their place (leaving teams vulnerable to echo chambers and groupthink).

While the insight of patients is under permanent scrutiny, the reverse is not true at all. In fact, it seems clinicians go to great lengths to avoid scrutinising the underlying motives of their own feelings, thoughts, words and actions. In pursuit of this avoidance, clinicians commonly attribute their own thoughts and feelings to their patient's presentation, often with the idea that because they have experienced a difficult or otherwise unpleasant thought or feeling, the patient is actually projecting this onto them, so they respond by projecting it straight back. This grim practice is cloaked with the clinical term "countertransference", and this "countertransference feeling" can be used as part of diagnostic processes: how someone supposedly "makes" a clinician feel can confirm diagnoses like BPD. When I have feelings about my clinician, those feelings are attributed to me and my past. When my clinicians have feelings about me, they are ALSO attributed to me and my past. Somehow, the clinician ceases to exist as an individual who has their own experiences and emotional reactions, and the patient becomes some kind of all-encompassing emotion monster, whose feelings are so enormous, they fill up the entire space, including the clinician.

Humans are capable of manipulating situations around them in an attempt to control, subvert, or direct other people's emotions. Everyone is capable of doing so, and I believe all humans do this, to different extents, with different motives, and with different levels of consciousness. However, feeling a certain way around someone (e.g. angry, annoyed, wanting to leave) does not prove that they are disturbed or manipulating you in some way. The individuals' thoughts, words, and actions may be difficult for you, because of your own personal situation. I like to think I am usually a reasonable person; I recognise that I have had ordinary interactions with mental health staff where I have felt difficult feelings and thought difficult thoughts, without those thoughts and feelings deliberately being pushed upon me by the clinician, or elicited because the clinician has some form of personality pathology. Reflecting on these instances I have the emotional insight to see that I have often been triggered by something specific to the interaction which has taken me to internal place of trauma, and I have reacted accordingly. Why is it that I can do this, but staff cannot?

Along with my own mental health difficulties, I have been a carer for various people in my life who struggle with their mental health. This began in my childhood, as I was a child carer for a parent with anorexia. What I've learned from being a carer is how to live with powerlessness and the feeling of not being in control. This is a very different powerlessness and lack of control to being physically unwell, mentally ill, or being a direct victim of trauma. To be a bystander to someone's pain is hard because the immediate desire is to fix the pain, both to protect the person in pain, but also to make it easier for you to cope. Sometimes this is not possible. Sometimes there is no easy, quick, or practical answer. Sometimes the only way to help is to just be there to sit with the person and bear witness to their pain while holding hope, which, honestly, can feel unbearable sometimes. Living in a permanent position of powerlessness, distress and uncertainty can feel impossible to cope with. In response to this, it seems understandable to want to escape, to put distance between yourself and the person who embodies this pain. This could be physical distance, by leaving them/ignoring them/excluding them, or, if this isn't possible, creating emotional distance. Emotional distance can look like reducing your feelings of empathy, blaming the person, feeling angry with them, centring your own feelings such as reinterpreting their words/actions as manipulative or directed at you, finding ways to make the person into a figure you can dislike. These are all protective and usually unconsciously done, and while I am not suggesting they are compassionate to the person in pain, they are understandable. Being a witness to pain, particularly from an involved position, like caring for someone you deeply love, can be incredibly difficult and sometimes people just reach the limit of what they can cope with.

This situation seems to frequently present itself in healthcare services, which I feel is where the "understandableness" of this reaction to the person in pain is lessened. Healthcare services are there to support people in physical, emotional, and psychological pain. Clinicians are aware upon entering this profession that this will be their role. It should be the responsibility of the professional to ensure they continually reflect on their emotional responses, what their feelings may indicate, and how well they are coping, and the responsibility of the service to provide high quality support for their staff, including clinical supervision, psychological support for teams, paid sick leave, and robust systems which quickly recognise burnout and compassion fatigue. There is no situation in which a person seeking help should ever be faced with a clinician who blames, excludes, and turns their own inability to cope back on their patient. In a profession where staff are certain to experience negative and difficult emotions in relation to the people they work with, emotional insight is an absolute necessity. It is vitally important that staff are able to recognise when their feelings and responses to a patient are actually based in their own difficulties. To illustrate this, I thought I would describe a situation I encountered a few years ago, where my GP's lack of insight put me in an extremely unsafe position.

I was seeing my GP regularly (pre-covid: oh, how times change) while going through a very severe period of depression with mounting PTSD symptoms. Initially, my GP did all the things in her GP handbook on how to support someone in my position – she gave me extended appointments, listened to me, gave general advice, prescribed anti-

depressants/benzos, advocated for me with mental health services who were being crap, called the crisis team and duty worker, put pressure on services to consider hospitalising me, and kept in touch with my partner about my risk levels. She did everything right, and honestly in those early days I cannot fault her. She was great. But I didn't get better, in fact I got much worse and became extremely suicidal. She reached the end of her list of things she could do and from my perspective this seemed to challenge her professional identity. She was a helper, that was her life. She had gone to the same medical school as me and we had spoken a lot about her progression through medicine. She was very enthusiastic about her job and had this very obvious passion for helping. But unfortunately in this case, she felt powerless to help me. If she had sat and reflected on what was happening, I think she would have realised that this wasn't her fault, she really was doing everything she could, and that she needed support to continue to be able to support me – but it seems this didn't happen because after a while, she couldn't cope and directed her distress back at me. Her manner changed entirely. Suddenly she was deeply frustrated, angry even, with my lack of progress. Her perceived failure to help me was turned around and became my failure to accept help. Despite trying absolutely everything she suggested, I was no longer "compliant". Despite me openly thanking her for her help and recognising that this was a struggle for us both, she expressed immensely upsetting statements, to the effect that I was being extremely "challenging" and "difficult" on purpose. I wasn't. I was suicidal, my whole world was ending, and eventually I would decide to make an attempt on my life… but my GP's poor insight into her lack of control over the situation, her perceived failure at her job, her struggle to understand why she couldn't help me, turned into this incredible anger at my failure to stop being ill. Obviously, this did wonders for my relationship with mental health services, who were now receiving desperate calls from my GP about how incredibly difficult I was being by steadfastly refusing to be normal and not suicidal. The emails between her and my psychiatrist (which I obtained via a SAR) were so revealing – two people comforting each other, for their own perceived failure and their struggle to cope with witnessing my pain, by dragging my name through the dirt. They felt bad, and it was easier to blame this on me, to suggest I was just "too much for anyone to cope with", than really think about what was happening for them. I think my GP was really truly aware that I was growing more and more likely to die, and by indulging in this anger she was also creating a distance between herself and me, to protect herself if I died. I understand it, it's human, but unfortunately for me, this complete failure to consider her emotions only served to make me more unwell. Not only was I desperately clinging to life, but now I had to deal with downright unpleasant interactions with someone who had previously been a huge source of support. My pain and my emotions had taken a back seat, to accommodate those of my doctor. I struggled to cope with this and decided that it would be best for us all if I discretely changed GP. I'm sure that sounds absolutely bizarre to many clinicians reading this – a patient managing their clinician's emotions and changing their entire system of care to accommodate the clinician. It's neither bizarre nor unusual. Mental health patients are not pieces of furniture. We are living, breathing, thinking, feeling people (gasp!) and are often excruciatingly aware of the feelings of the people tasked with our care. I personally don't know anyone under services who has not acted in some way to protect staff – perhaps from fear, anxiety, uncomfortable truths, protected them by censoring

the graphic details of past trauma, protecting them by using euphemisms for suicide and self-harm etc… The sad thing about this is, firstly, this usually goes entirely unrecognised (to the point of it being spun the opposite direction where clinicians actually perceive their patients as being deliberately provocative) and secondly, this takes energy. I should not have had to contend with my GPs emotions during a period of crisis. I should not have been forced into the position of lying to her, telling her I was suddenly better, and then switching to a new GP practice. This cost me emotionally. This took the focus off me and my safety, and in the end, almost cost my life.

No matter how many campaigns exist which describe healthcare professionals as angels and saints, HCPs are still human. Denying this fact only denies the legitimacy of their emotions, which is detrimental to everyone. It is not easy to support people when they are in immense pain, particularly when that pain cannot be easily solved, and you are the person tasked with solving it. However, to provide compassionate, effective care, clinicians must continually reflect and recognise that their emotional responses to situations are not necessarily a sign of deliberate manipulation; an attempt from the patient to make the clinician feel bad; or an indication of personality pathology; and that the urge to avoid, dismiss, or blame the patient likely arises from a personal struggle to deal with the situation. Insight into this can save patients a huge amount of further pain.

There is a desire in medicine for professionals to see themselves as objective spectators. This seems particularly strong in mental health services, as little objective evidence exists in support of psychiatric disorders or the psychiatric model. But healthcare professionals are not objective, and in a specialty like mental health where interactions and relationships are so central, insight into how your feelings, experiences, and understanding of the world affect your interactions and relationships is absolutely vital, and potentially lifesaving.