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Assessing and Improving Clinical Insight Among Patients “in Denial”

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Vexing challenges arise in clinical care when patient preferences are at odds with the standard of care. In the hospital setting, such patients on a medicine or surgical service may come to the attention of the psychiatric consultant when “denial” is viewed as an obstacle to appropriate care. In the outpatient setting, these patients are more likely to miss appointments, have persistently poor outcomes, and risk polypharmacy and serial hospitalizations.¹ Patients with chronic disease and comorbid mental illness are an especially complicated population in this regard, increasingly recognized as commanding a disproportionate share of health care spending while experiencing inferior outcomes.² These trends are even starker for patients dually diagnosed with substance use disorders.³ While such patients may represent but a fraction of the nation’s overall population, their effect on the clinical delivery system is profound.

As the implementation of the 2010 Patient Protection and Affordable Care Act and the 2008 Mental Health Parity and Addiction Equity Act unfolds, patients with limited insight present particular challenges to physicians who face mounting incentives to engage them in order to improve outcomes and reduce health care costs. The realignment of clinical care will benefit from greater involvement of mental health physicians as consultants and team members in the general medical setting, especially for patients with limited insight.

The terms *denial* and *lack of insight* are often used interchangeably but may have quite different meanings depending on clinical context. Following Freud’s work in the early 20th century, denial has been understood as a psychological defense that can, under the right circumstances, be protective and normative. In this model, denial is viewed as supporting the patient by preserving hope in the face of a poor prognosis. For example, denial may initially be adaptive in helping patients newly diagnosed with cancer face the future but may

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become maladaptive if it prevents them from recognizing the need for intensive treatment or writing a will.

While denial may be best thought of as a psychological defense ubiquitous throughout the human experience of being ill (on a spectrum of adaptiveness to maladaptiveness), lack of insight is a dynamic, multidimensional attribute stemming from a potential combination of primary symptoms, neurocognitive deficits, and cognitive style. In its most extreme form, a complete lack of awareness (at times referred to as *anosognosia*, controversially borrowing from disorders with clear neurologic etiopathogenesis) is found in roughly half of patients with severe mental illness, such as schizophrenia and bipolar disorder, and is associated with treatment nonadherence.²

Notably, a growing body of evidence suggests that lack of insight may involve neurocognitive deficits that are not disorder specific.⁴ The pathophysiological cause of unawareness in schizophrenia is increasingly understood to have neuropsychological underpinnings implicating frontal and temporal lobe dysfunction, especially the anterior cingulate and dorsolateral prefrontal cortex.⁴

The so-called denial of illness characteristic of some individuals with substance use disorders may elicit a strongly negative reaction from frustrated health care professionals but in fact may represent a related form of nonvolitional impairment of insight driven by dysregulation of self-appraisal, error monitoring, and executive functioning.⁵ In other words, the dysfunction of the neural circuitry implicated in insight can significantly overshadow the psychological defense of denial.

Cognitive style also contributes to the capacity for insight in the context of a particular diagnosis. Beck and colleagues developed the Beck Cognitive Insight Scale⁶ to assess insight, with a focus on cognitive processes facilitating self-reflectiveness vs self-certainty. Patients who score high on self-certainty and low on self-reflectiveness demonstrate more impaired insight; such findings have been correlated with the results of neuroimaging.⁴ Recently, interest has developed in metacognition, raising the possibility that the ability to self-monitor mediates the relationship between cognitive deficits and poor insight.⁴

For many patients, lack of insight may be a combination of primary symptoms, neurocognitive deficits, and cognitive style. Instead of a dichotomous variable (whereby patients either have or do not have insight), insight might best be conceptualized as a dynamic, multidimensional attribute.

Understanding insight in a more complex way can help physicians across many clinical settings identify points of resistance to treatment adherence among patients as well as opportunities for intervention. Amador and David⁷ usefully outline 5 core components of insight, which are awareness of having a disorder, awareness of symptoms, attribution of symptoms to the disorder, recognizing the consequences of symptoms, and appreciation of need for treatment.

Some patients with limited insight into their symptoms, disorder, or their consequences may nevertheless appreciate a strong need for treatment and adherence. Alternatively, patients

may have insight into having certain symptoms or a given diagnosis but may nevertheless lack an appreciation of the need for treatment. Interventions to improve adherence by enhancing insight likely need to address multiple components through a combination of cognitive and psychosocial approaches.

Shared decision making and motivational interviewing may improve understanding of patient decision making and whether addressing specific barriers is likely to increase treatment adherence.⁸ For the same reasons that these approaches may facilitate healthy decisions among patients with psychotic disorders or substance use disorders, they can also aid physicians working with patients with diabetes mellitus who are intermittently adherent to their insulin regimens. Rather than approaching lack of insight as deliberate denial, both techniques strengthen reflective, open, and adaptive processes to help patients make more informed and self-determined choices in the service of improved health.

There are times, however, when techniques of shared decision making and motivational interviewing are inadequate, such as with comorbid mental illness that goes unaddressed, unremitting drug dependency, or cognitive impairment. Care pathways for these patients eclipse the sole physician and benefit from collaborative and integrated models that are better suited for coordinated longitudinal care and case management.^{2,8} Primary care physicians can establish formal relationships with mental health physicians (collaborative care) or integrate specialists within their clinical settings and electronic medical record systems (integrated care). For example, Katon and colleagues¹ studied patients with chronic disease (diabetes or coronary heart disease) and depression randomized to an integrated care model or treatment as usual. They found that patients in the intervention group had improved adherence, superior health outcomes, and lower outpatient costs.

In summary, while denial may be best thought of as a psychological defense commonly used throughout the human experience of being ill, lack of insight is a dynamic, multidimensional attribute situated within the context of a given patient's clinical presentation and cognitive style. Reflection on lack of insight as a complex variable available to multiple levels of intervention may help broaden the differential for what is first perceived simply as denial and, it is hoped, cultivate opportunities for improving care. A significant number of patients with complex comorbidities, however, may require services within structures that offer collaborative and integrated care beyond the physician-patient dyad.

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