Bulletin of the *Transilvania* University of Braşov
Series VI: Medical Sciences • Vol. 5 (54) No. 1 - 2012

ETHICAL SIGNIFICANCE OF LACK OF INSIGHT AND INFORMED CONSENT IN SCHIZOPHRENIA

V. BURTEA[1] **L. ROGOZEA**[1]
P. IFTENI[1]

Abstract: *David (1990) identified three over lapping dimensions in clinicians use of the term insight:*
a) the recognition that one has a mental illness;
b) the ability to relabel unusual mental events as pathological and compliance with treatment.
All these aspects can occur independently and need not follow a fixed sequence or simple hierarchy. The four criteria (objectivity, materiality, independence and ethical significance) and their application to lack of insight in schizophrenia increases the chance that persons in like circumstances will be treated equally. Because insight equals or exceeds incompetence on each of the four criteria, intervention based upon lack of insight is more legitimate and ethically justified.

Key words: *schizophrenia, insight, ethical significance.*

Most researchers concerned with the clinical relevance of the concept of "insight" (own conscience disease) in schizophrenia have accepted the notion as a multidimensional construct. Although there are certain scale that assesses awareness of the disease (Cuesta and 2000) certainly the most valuable evaluation is separately and not as a component of any scale.

The disease conscience "Concept specificity" is defined from the beginning. It includes the traditional "psychiatric" area such as awareness and the award of their own behavior versus another, awareness and allocation of certain symptoms, but not others, as well as awareness of deteriorating cognitive functioning, interpersonal, behavioral and involuntary movements.

Awareness of disease is associated with psychopathology, and thus is influenced by the level of clinical psychopathology (the presence of positive, negative, cognitive, emotional symptoms) (Hayashi et. al. 2001).

It is correlated with the prognosis of family variables, compliance to treatment and voluntary or involuntary internment in a hospital. On the other hand it would be wrong to emphasize the implications of awareness on the disease prognosis in

[1] Faculty of Medicine", *Transilvania* University of Braşov.

patients with schizophrenia, as long as it is only one of the many actors involved and may be confused with factors such as and cognitive deficits and / or executive function.

On the stability of the disease awareness during the disease episode, several researchers have revealed that at the beginning of an episode the conscience tends to correlate positively with the disease awareness at the end of episode, seeming to be a feature of the behavior of the patient. Awareness of the early disease, at the beginning of the disease, improves the alarm systems and in this way entails early therapeutic interventions who come to improve the overall functioning of the patient (Corrigan, 2002; Croghan et.al. 2003).

On the other hand it was observed the correlation of disease awareness with depressed mood, although the meaning of this relationship is far from being clarified.

David (1990) has identified three dimensions that overlap in use of the term conscience of the disease by clinicians:

1. Recognition by the person in question that suffers from a mental disorder
2. The ability to consider some unusual mental experience as pathological;
3. Compliance to treatment

These aspects of disease consciousness may occur independently and do not require a strict sequence or ranking. Thus, as many experienced clinicians have observed, some patients come into regular medical checks and they take their medication properly without being convicted or exposed, despite the fact that they do not agree with the diagnosis or with the specific meaning of the symptoms "I take Zyprexa because it helps me sleep", they say.

Last decade was characterized by substantial efforts in developing tools for measuring the conscience of the disease of patients with psychotic disorders. Thus this biomedical notion of disease awareness was adopted as being composed of three independent dimensions:

- Disease-awareness,
- Awareness that psychotic symptoms are abnormal and acceptance of the prescribed treatment (Sanz et al 1998; Peralta and Cuesta, 1998; Weiler et al 2000; Cuesta et al 2000).

Unfortunately this type of research has neglected the social determinants of disease awareness. As a result, inquiries have been reduced to measure the degree to which patients with psychotic symptoms agreed with their doctors explanations about their behavior and experience. This approach has produced a false dichotomy in which individuals who did not agree with the doctor were considered to have a lower disease-awareness, while those expressing an understanding of their medical symptoms were considered as having the consciousness of the disease. This approach ignores factors such as culture, ethnicity, religion, gender, social class and education, factors that have an obvious contribution to the collection and interpretation of psychotic symptoms of the disease.

Johnson and Orrell (1995) have also suggested that the stigma that lies on mental illness in many societies may cause many individuals to deny their whole symptoms in order to keep, in this way, the social status and social relationships. Such an individual may reject a medical explanation, not because of a lack of conscience, but because he gives priority to maintaining relations and social position

which otherwise he would lose or would endanger it.

In 2002, Carter reveals that African-Americans often invoke religious or supernatural explanations for mental illnesses that weaken compliance to the biological treatment, and those are often labeled as lacking disease conscience.

Psychosocial studies suggest that a better knowledge of itself is not so much based on direct observation of their mental functions or their own behavior. It is regarded as a cognitive scheme, collective representation and continuous negotiations with patients, families, clinicians and other factors involved to its meaning. Disease awareness reflected in this aspect the conscience of knowledge in that culture.

A series of investigations have revealed that the symptomatology, self-addressing to a medical department, or seeking care and the development of schizophrenia are strongly influenced by cultural interpretations to such a degree that culture can fingerprint "natural history" of the disease. There were such data that have shown that schizophrenia has a better prognosis in developing countries versus developed ones (Leffe, J., Sartorius, N., Jablensky, A., Korten, A., & Ernberg, G. 1992, The International Pilot Study of Schizophrenia in an international pilot study on schizophrenia (IPSS).

Disease awareness should be in view of Kress, K. (1999, 2000) to play a significant role in mental health legislation, particularly in the placement and involuntary treatment against the patients will. He showed that the lack of awareness of disease could play a role in high legal doctrine that justifies treatment against patient and involuntary internment of it.

Disease awareness in the context of mental illness means traditionally the consciousness of illness existence and awareness of the treatment need of the mental disease. But it is crucial to understand that the consciousness of the disease can not be understood without exploring the patients reasons to believe that disease, the need for treatment, symptoms, the value of the treatment, the social acceptance of that disease.

Four factors determine the extent to which a disability justify the privation of freedom through no voluntary internment:

1. **Objectivity**. Disability must be objective (episteme requirement)

2. **Reality**. It is necessary that there is a real base (or a demonstrable medical syndrome) for disability (ontological criteria or constitutive), which means that the disability can be seen as resulting from brain and neurological system. Materiality means that the disability should originate in the brain.

3. **Independence**

Episteme criteria of disability existence must be substantially independent accordingly to the negative outcome (prognosis); the decision must be prosecuted in terms of its justification, which in turn take account of the rational and of what clinician considers true, based on the information already known, taken in support of the outcome and not only regarding the outcome itself. A decision is good or bad depending on the quality of what underpins its rates rather than the desirability of its outcome. Part of this criterion is that even the best (non-deductive) thought has sometimes a false result or conclusions are wrong. Indeed the

chronically mentally ill show relatively frequent judgmental errors leading to false or absurd conclusions. Tversky and Kahneman concluded that most people, probably including theorists, Bayesian statisticians, empirical researchers and psychiatrists frequently make probabilistic and statistic judgmental errors.

To determine the extent to which a decision is responsible, the target should be the decision and not the conclusion that will be reached. Correlation of the three factors above exposed is not easy in the context in which many people, including patients, have difficulty in expressing their judgments. Finally, because we are not infinite beings, with an infinite memory, we often remember the findings but not the judgment that have lead to them.

4. **Ethics significance.**

Most importantly, the decision must have an ethical significance to justify the intervention taken. Theory and the current laws, justifies involuntary internment and treatment trough "Law on Mental Health and Protection of Persons with psychiatric disorders No. 487/2002, filled with 372/10.04.2006 Order".

Involuntary treatment is justified on the basis of inability to judge the principles and goals but will have to take account of the somatic health, any co-morbidity, certain adverse effects related by the patient, information, earlier FOCG etc.

The disability justifies involuntary internment and involuntary treatment as a significant reduction in ethical freedom.

The absence of the conscience of the disease is a cognitive disability justifying the intervention in those circumstances in which it interferes with making informed decisions. By contrast, incompetence or inability to reason, to weigh, to put things in balance, acts in the absence of practical skills (especially in case that is the best way to achieve their goal) referring to the inability of a person to achieve the certain purpose trough the best way.

In fact, in the case of incompetence to justify the placement and involuntary treatment, deficits in practical ability to judge must be shown. From the ethical point of view, the lack of disease conscience is meant to be a central piece of information needed to motivate the decision to establish a treatment, which, if missing, it can lead to self-destructive decisions in chronic mental patients.

The new theory on disability justifies the paternalist intervention as it applies in the absence of the disease conscience. Lack of awareness of disease operates as a central piece of knowledge, and not as an autonomous skill or experience, and therefore it is better justified and less ambiguous in its application than the inability to discern. Lack of ability to judge practically does not justify this paternalist theory in general, so that the intervention based on the lack of awareness of the disease is more legitimate and more justified than the intervention based on incompetence.

The four criteria listed above make disability capable to justify involuntary internment. Working together as a unit, they make the whole superior than the facts, separately added. The requirement that the disability should be independent from a negative prognostic, coerce the law to provide disability in another meaning than the value differences between state and individual. Inter-subjective requirement of objectivity, understood in the context of reliability, increase the

chance that mental health professionals and the courts to agree on the disability existence, and on that, that whatever may happen, disability justify intervention. In this way the chance that a person in these circumstances should be treated equally is increasing. The requirement of the material base also stresses the equality perspective, increasing the safety and effectiveness of social wealth. Moreover, greater equality and safety increases the freedom by identifying those behaviors that are unlikely to lead to paternalist intervention. However, equality alone may not be a virtue. The requirement that disability should justify involuntary internment tends to make the individual sure that he is treated with care and respect equal to any other person.

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