

## The psychopathology of insight\*

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About insight as a psychiatric problem little has been written; but in many places more or less casual evidence may be met with of prevalent notions which seem loose or ill-founded. In order to clear the ground a formal and necessarily incomplete essay is offered as a basis for further clinical study.

Insight is not a word of plain and single meaning. For a Gestalt psychologist it is an act or an ability to effect a direct configuration, a connected whole which is evident in the meaningful reaction to a stimulus-structure. Spearman seems to mean by it the quality in consciousness that attaches to belief based on adequate (self-experienced) evidence. In ordinary speech it refers to the quality by which we penetrate into the essence of things or happenings. In psychiatry, it is none of these things. Where its meaning is not assumed to be self-evident – and vague; or restricted to delusions, in which *ex hypothesi* it is impaired, it is said to cover “the amount of realization the patient has of his own condition” – a quantitative relative judgment by the physician, expressed in such terms as “total lack of insight”, “little real insight”; or a, often implicitly all-or-

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nothing, quality, a realization of the mental or “nervous” nature of the illness, something which psychotics have not and neurotics have. A further usage, rare among psychiatrists, is to denote an appreciation by the patient of the presumed motives and genesis of his symptoms; this is sometimes called “psychological insight”. In the text-books the diversity of meaning attached to the word appears in the form of discrepant statements and even polemics.

It is therefore especially desirable to consider the antecedents of the word and the meaning to be attached to it. Originally it meant internal sight, *i.e.* seeing with the eyes of the mind, having inner vision and discernment. This is closely akin to the earlier meaning of the word “consciousness” as the mind’s immediate cognition of its own experiences. The French still use the same word for both. Later it was turned outwards and meant a mental regard or consideration of things, and so arose its current meaning “the power of penetrating with the eyes of the understanding into the inner character or hidden nature of things”. Clearly the psychiatric usage is closer to the early than to the current meaning. It is concerned with looking inwards rather than looking outwards. I would offer as a temporary definition of insight for purposes of medical psychology and clinical medicine, that it is “a correct attitude to a morbid change in oneself”. This definition is by no means final, needs much explanation and is here used chiefly as a convenient text. Each of the four terms – correct, attitude, morbid, change in oneself – calls for discussion.

For a patient to have an attitude towards changes in himself it is necessary that evidence of these changes shall be available to him. One could not have an attitude towards gangrenous changes in a limb, if the sources of information were cut off – if the affected limb were anaesthetic, one could not see or smell it, and no one spoke of it. Where there is a mental change – I use the dualistic word for obvious reasons– it must likewise be accessible to consciousness in some way if one is to have an attitude towards it. It may be said that consciousness has little to do with it; but we can judge insight only by the patient’s behaviour and especially his utterances, *i.e.* his expressed attitude towards what is accessible to his knowledge – accessible but not necessarily present in consciousness. Of physical changes, there may be an immediate perception making use of the usual channels, or there may be judgments on secondary data, *e.g.* comments by others (as in ozaena) or difficulties in performance; reference to the two kinds of data may be expressed as “there is a change” and “there must be a change”.

Are morbid mental changes similarly accessible to consciousness? It is an old and familiar observation that we have an attitude – one of notice or regard – towards our own mental experiences; in other words, that they have a tendency to appear in consciousness, though not always, nor necessarily, nor in a differentiated form. We not only think or see but know that we think or see.

Various factors have been invoked – a self-observing tendency such as Schilder and others described has been given various names – and there are philosophic and psychological battle grounds of all ages in this territory. I shall not enter into Professor Spearman's masterly presentation, nor into the subtle windings of some Theseus tracking the super-ego. I would only emphasize the possibility that with every mental activity – or act – there is an observing and registering of its apprehended quality apart from the material upon which the function in question is being exercised. Since of course mental activity is a fluid continuous happening, the observation maybe correspondingly continuous, but subject to secondary isolation of temporally limited experiences; much of the dispute as to whether introspection must always be retrospective turns on this last point. It is relevant to the question of insight into past psychosis which I shall touch on later. At this point I would speak only of present mental happening. To take an example, I not only see a horse but I have a cognition of my seeing – a particular and to me familiar experience to which ordinarily I pay no heed. If I am a practised introspectionist, in certain circumstances I pay tremendous heed to this happening, ignoring for the most part the material of the function, *i.e.* the horse. If I have a mental disorder, the function may be disturbed, as is most strikingly seen in depersonalization: it is no longer the familiar happening but a changed one; the more sudden or extreme or unpleasant the change the more will I be perplexed by it or the more will I attend to it. Here the apprehension of the experience is an immediate datum of change. The apprehension of it in consciousness is not necessarily full, but it tells me a great deal of what the experience is, the changed experience; I am aware of it in itself as well as of its effects in the form of particular perceptions, thoughts, etc. To separate a psychic tendency from its material is as difficult as to distinguish form from content or function from structure, but it is the only way, I think, of doing justice to the experience of a dynamic process: in so far as the change extends to all experiences of the kind, the common quality of these represents the function. Restating what I have said: where there is a change of quality in mental functions there will also be a tendency to an awareness of this change (I say "tendency" for much the same reasons as those of Spearman in the statement of his first noegenetic law). It is often said in discussing the findings of Külpe's pupils, and other introspection based on the Würzburg methods, that experience must be objectivated in order that it may be cognized, but I would prefer to say that for the apprehension of change, the immediate experience is subjective, and only with the attempt to describe it is there objectivation and so approximation to the secondary data to be referred to below.

There are, then, in some forms of mental disorder immediate data of change-some of them of somatic origin, others psychic, thought developmentally all must be referred to bodily experience, and commonly both are experienced

together and not differentiated. I know it may be urged that in mental disorder there is no change in quality of functions but only rearrangement, modification or regression. I do not accept this view, finding it unsatisfactory, or at any rate premature, to account for the phenomena of perverted function in terms of earlier stages of normal development; but even if it were so the change would still be experienced as a change from the familiar established happenings. I am not going so far, however, as to say that there is some change in quality of function in every mental disorder, nor even that it is invariably apprehended consciously in some degree when it exists. A lengthy clinical study such as I may later have opportunity of presenting in connection with depersonalization and related states could alone deal with the range of such disturbances. I think the range is a very wide one. There are disorders in which the change is quantitative; there are others in which it has come on so gradually that than we ordinarily have of our own non-abrupt developmental changes, say, of affect or cognition. It is a matter of general psychopathology. I said earlier that the suddenness and extent of the change and the unpleasantness accompanying it would be important in determining how far it reached consciousness. This is not a precise or exhaustive statement, but I have intentionally excluded as a factor the possible unconscious symbolical value and meaning of the function, because I do not know of any evidence in favour of it, though of course there is a great deal to be said for the influence of this on the presentation in consciousness of the material of a function.

I have dealt with this question of immediate data at length because it is customary to assume that the acquiring or having insight is a matter of judgment. That is quite true, but it is also assumed that the judgment is exercised only on the same material as the physician or other observer uses for forming his opinion of illness or mental illness – which is false. That material is no doubt also available to the patient in large measure. But he has also these immediate data, accessible only to himself, and their importance is, I think, worth labouring. Insight is concerned primarily with the awareness of the change, and secondarily with the judging of this change, as to whether it is illness or demoniacal possession or insanity (which may not for him be the same thing as illness affecting chiefly his mind) or religious conversion or some other remarkable intervention.

In addition then to the immediate apprehension of a change in mode of function, it is possible to have what might be called secondary evidence of change in oneself – a lessened capacity to calculate, let us say (borne in upon one by mistakes at work or rebukes), or to make people interested in what one is saying – though I hope that is not always a sign of mental illness. The behaviour and social or other effects of this from which we ordinarily recognize a change in another person – all this is potentially available to the patient and is to be regarded as secondary evidence of change so far as he can observe and objectivate it.

From such data then, somatic and psychic together, the patient may arrive at a knowledge that he is changed. His communication of this knowledge is our first ground for assessing his insight or, more correctly, his requisite for insight. Much of his difficulty in describing the change will be due to the inadequacy of words to cover such unfamiliar experiences.

What is a correct attitude towards this change? It is commonly taken to consist of a realization of illness and, since it is psychiatry we are concerned with, a realization that the illness is mental. If we require this of the patient we must be clear as to what we mean ourselves when we speak of illness, mental or nervous abnormality, and what he means by it. Different groups of people have divergent conceptions in this matter.

The normal is either a statistical or an ideal conception. In neither case does it necessarily tally with the healthy. The statistical norm of mind is for the most part almost impossible of description because of the difficulty of measuring mental attributes. The ideal norm, say of Kant, would set up a canon of harmony, dependent on fluctuating non-experiential values, ethical or aesthetic, which would serve as a standard for comparison but not as an immediate empirical criterion of normality; it might be that no man would by such a standard be judged normal. If biological or social values be used for the ideal norm, it comes very close indeed to the conception of being healthy. Those qualities of reaction would then be regarded as normal which serve the end of appropriate adaptation to the environment. The better the adaptation the more definite the normality. Normality will then vary with local and temporal social conditions. Its scientific value is therefore restricted. A third view, to which Kronfeld calls attention, is that everything which follows natural laws is regarded as normal. But since the abnormal follows its own laws one must then say that that is abnormal which does not correspond to the laws determined for the majority of phenomena or for the commonest, the laws found to have the widest validity.

These are the three, on the whole unsatisfactory, norms – the statistical, the teleological and physical; it need hardly be said that in ordinary usage all enter into the words ‘normal’ and ‘abnormal’, and that they roughly cover each other. It is a normal attribute to consider oneself, one’s permanent whole self, as approximately normal, though not necessarily as to detail. The changes referred to earlier in this paper will be regarded as deviations from this norm.

Abnormality, however, is not disease. A genius is abnormal, but he is not ill. A tiny well-set-up dwarf and a mystic have this in common, that they may be quite healthy but are quite abnormal. What then is the conception of the morbid, this variety of the abnormal? Let us consider first the higher ranges – the views of theorists and careful thinkers. Of physical conditions – and it is of these that most people think when they speak of illness – those will be called morbid in

which abnormal cellular or humoral phenomena are accompanied or followed by discomfort, limitation of activity or danger to life. It is a teleological conception, arbitrarily making use of biological values. It does not admit of strict definition. What then is morbidity in the mental field? For some psychiatric theorists it is a matter of quantity – a mental anomaly becomes morbid only when it reaches a certain degree (Wilmanns); for others it is a value-concept (Wertbegriff): to be ill is to be from some point of view harmful, undesirable, inferior (Jaspers). Both these views may be combined as in Kraepelin's opinion that personal variations from the normal line of development can be called morbid when they acquire considerable (harmful) meaning for somatic or psychic life. Bleuler also arrives at this conclusion, putting emphasis on the social criterion. Clearly these are not precise definitions, any more than Allbutt's "absolute health is an ideal conception... it is a positive conception of a perfect balance of the moving equilibrium which we call systemic life: disease is a negative conception and signifies something less than this perfect balance". The difficulties of comprehensive, yet sharp, definition are well illustrated by the numerous controversies as to whether the psychopathies are to be regarded as mental disorders. The heated assertions about psychosis and neurosis are equally good evidence of the different and vague conceptions prevailing among psychiatrists regarding mental illness. It is clearly not otiose to discuss it now, since it is the psychiatrist who must judge a patient's insight by his realization of mental illness.

There is a discrepancy, not to say confusion, between everyday usage and scientific requirements. Neither has any time for the third or metaphysical conception, a denial of any distinction between health and illness, allied to which is the 'metapsychological' notion that "normality may be a form of madness which goes unrecognized because it happens to be a good adaptation to reality".

In ordinary life phenomena, whether physical or mental, are judged to be morbid on other than biological, or somatic pathological, or 'metapsychological' grounds. Physicians occupy an intermediate position, I think, between the public and the thinkers. Except in so far as they are captured by the current lay attitude, they regard those phenomena as morbid which conform to the descriptions in text-books and the experience gained in hospitals and consulting rooms, reinforced by special knowledge or theories concerning the bodily changes and mental 'mechanisms' or developments; symptoms are signals to be evaluated according to their setting. But the non-medical layman has rather different attitudes towards illness, different notions of what is morbid. Moreover, his attitude towards physical disorders is not by any means the same as towards 'mental' ones. So far as the former are concerned he is an adherent of the school of Cnidos: the disease, the thing that comes from without, is the essential: it attacks, and symptoms are the means by which the victim becomes aware of its ravages. If

one feels pretty well, without pain, able to do one's work, then one is healthy. Each disease is fixed by nature and is characterized by certain symptoms as an animal or a plant is characterized by its particular qualities. It is conceded that diseases may "lurk in the system", but even in such cases a really good doctor would discover the appropriate symptoms. At any rate, many hold that until the disease makes itself felt by the patient in the sense of discomfort or limitation of activity he is not ill. Such a view has this much soundness in it, that it pays regard to the whole man, who is considered ill only when his full life is interfered with through bodily discomfort.

So much for the everyday, or everyman, view of physical illness. Mental illness is judged on different grounds. So far as madness is concerned it is doubtful whether, except among the better informed or the more reflective, it is regarded as illness at all in the sense commonly used, though lip service may be paid to the medical conception of it. It is still looked upon by large sections of civilized people as an obscure visitation often with implicit moral or social obloquy, to be ignored, laughed at, shunned or euphemized. Its manifestations are referred to an empirical standard of normality qualified by social criteria, and made up of daily experience of one's own mental activities and one's inferences as to the ordinary range of behaviour and the motives underlying it in the majority. Neither the murderer for gain nor the malingerer are commonly regarded as mad, since most persons can enter readily into their supposed or possible motives. It is useless to deny the existence of this everyday psychology. It is of course really a matter of *Uneinführbarkeit*: it is difficult to enter into strange kinds of mental activity or extreme exaggerations of familiar kinds. If the person's behaviour, though *üeneinführbar*, be in conformity with that of a group of socially useful people, or have socially useful fruits, or even be socially unobtrusive, he is not described or (more correctly) stigmatized as insane. For the vulgar, to say of a particular mystic that he is also insane is not to make parallel diagnoses using different values but to belittle his achievements. Intoxication with alcohol is not regarded as morbid because it is sufficiently common and within the range of personal experience to be easily entered into and 'understood'. When, however, it results in gross antisocial conduct the view of it as temporary insanity may be entertained, unless routed by ethical considerations. Similarly, odd types of personality are described as eccentric rather than mad unless extreme, incomprehensible or antisocial. Since these are the conceptions of madness which most patients bring to a consideration of changes in others or in themselves, it is not idle to consider them fully in a paper on insight.

It may be urged by some that a primitive experience of madness lingers in us as a trailing cloud from our 'panpsychotic' babyhood, and that it is not at all an attitude such as we have towards others that we use in judgments of

ourselves when insane, but rather a primitive dark knowledge which comes more or less to consciousness. Such intimations of insanity from recollections of early childhood are a theme which I find it profitless to pursue.

So much for the popular notions of physical illness and of madness. There is, however, the intermediate notion – ‘nervous’. Here structural changes in the nervous system, or varieties of personality are included: or the occurrence of symptoms familiar in disease where there is local structural damage, but here declared by doctors to be unaccompanied by such local lesions; or finally the term ‘nervous’ refers to mental abnormality either mild and more or less understandable in form, frequency and persistence, or else unaccompanied by striking changes in the personality. In short, it covers pronounced types of personality, mild mental abnormalities, and symptoms suggesting physical change but competently judged not to be due to them, *i.e.* symptoms without that concrete and palpable menace to life that there is in physical illness. Also of course it covers definite disease of the nervous system. If then we expect a patient to arrive at a conclusion that his illness is nervous, we are in many cases expecting a very remarkable exercise from him.

In asking for complete insight in any mental disorder we are setting the patient a very remarkable exercise indeed. It is an ideal requirement, impossible of attainment. What is complete insight? – “a correct attitude towards a morbid change in oneself”. We have considered what is a morbid change (in the patient’s use of the related words for this), and how he may become aware of the change: also it is clear that we cannot expect of him anything more than that he should stand over against these changes, and with or without guidance arrive at an attitude towards them which lies somewhere between that of his associates or his former healthy self, and that of the physician: such an attitude is a ‘correct’ attitude. The psycho-analyst may expect an attitude ultimately much more like his own than would a psychiatrist whose treatment had been unlikely to make the patient acquainted with the particular theory of psychopathology illustrated in himself, and who would expect little more than that the patient’s attitude should be that of an ordinary layman of his own sort, socially, intellectually, etc. But for everyone the criterion of the correctness of insight is the attitude of a non-affected person, whether it be physician, layman, or the patient when he is healthy. This I repeat is an ideal requirement.

Let us consider first the easier instance of a physical illness. It is commonly assumed that the ordinary person with a physical illness has ‘complete insight’, *i.e.* that he views his symptoms objectively as another person would. But everybody knows that this is not so and that people vary widely and inevitably in this respect. An identity of bare statement may be the only common ground – “I

have such and such a physical illness”, “He has such and such a physical illness”: the attitudes, however, are necessarily far apart. The data on which opinion is formed are not the same for the sufferer as for others, nor can the phenomena be viewed with the same kind of detachment by him – I am sorry to labour anything so obvious. The familiar forces which are at work in one’s attitude to oneself must here be effective – forces which are only in limited measure present in consciousness. There is no theory of psychopathology which can neglect the preponderant rôle of one’s body in giving substance to consciousness and relevance to reality. It is not to be supposed that a significant change in the body can leave the mind just as it would be if there were no such change. The patient’s deference to the opinion of others, especially doctors, his concern about the effects of an avowal of his attitude in the face of what he recognizes to be a different attitude on the part of those round him, and his inadequacy or economy of language, may give a false impression of complete insight. But there are numerous instances of grossly defective insight in physical disorders. Spes phthisica may be the last rare striking manifestation of a year-long peculiarity of attitude to chronic tuberculosis. A physician (L. P. Mark) has related how for fifteen or twenty years he remained blind to the patent acromegaly which confronted him every morning in the mirror as he shaved, and of which all his friends were aware. Gibbon thought nobody knew of the hernia and hydrocele which hung conspicuously down to his knees. Failure to appreciate hemianopsia or monocular blindness is fairly common – I saw only recently a boy with advanced optic atrophy who insisted, in spite of evidence, that he had some vision in the blind eye, and that it was improving. Such failure to appreciate blindness, deafness or paralysis has been reported in focal lesions of the brain by many observers, and the condition has its own name among neurologists. Phantom arm is a relevant phenomenon. Guttmann has referred, and so has Mayer-Gross, to the defective appreciation of symptoms that is common in frontal lesions. It is not sufficient to explain such phenomena only as psychogenic: there is a physiological disturbance of cerebral function, interfering with the integration of the contributory or part function. This is not to deny the concomitant familiar psychic influences such as have been described in innumerable books and papers.

Now it may be said that physical illness is commonly a response to an external noxa, and the patient has an attitude only to the (physiological) effects in himself of this noxa, whereas in mental illness it is from himself that the symptoms spring, from his mind and its appetencies as it were, and that his attitude to such mental happenings will be influenced by his unconscious knowledge of the motivation of the symptoms. Brill has written a paper on unconscious insight. Hollós and Ferenczi have investigated it in general paralysis. This would be paralleled as to physical disorders by the extreme views, say, of

Groddeck. But this view has no force unless a coherent and comprehensible psychopathology, in terms of unconscious and conscious, is available and is held to represent the whole of the psychic happenings. This is a view I do not hold. The distinction is fundamental. If all psychic phenomena are the expression of forces which transform experience, invest it with equivalent (symbolic) significance in a vast 'unconscious' which is at any rate a field of 'knowing' in some sense, and of storing, then apprehension including judgment of illness will be, through a more or less distorted arrival into consciousness of an 'unconscious' presentation of these 'unconscious' happenings. This is not what I have supposed to be the case. In the literature of psycho-analysis I can find no clear expression of the supposed relations in such a case, and even if there were such a clear view its clarity would not argue cogency.

The data of change are limited, I think, to those I have mentioned earlier. So far as immediate vague awareness of a mental change is expressed – "I don't know what's come over me", "I feel my mind is going" – these, I would emphasize, refer to a contrast or change in the quality of experienced function, not to the appearance of a lasting unconscious capacity for the recognition of certain 'psychotic' motivations. Also in mental disorder there are the data not so immediate, which are in some measure available to the patient as they are to others, *e.g.* paralysis, stammer, perverse behaviour, etc.

The way in which the patient describes these data or communicates his judgment on their significance will depend of course partly on his words. I saw lately, for example, an obsessional patient who assured me that his trouble must be 'mental' –, "it's not natural thinking, all these foreign thoughts oughtn't to enter a man's mind, or he ought to be able to fling them off. It's as if I was possessed. And I am asking myself all the time why, when and wherefore. I feel different. I am not as other men are. I think it's mental because I do such silly tricks. It's a slight form of insanity of course; I think there's a very small margin between sanity and insanity". Here is a man offering two interpretations of his changed experience –insanity, or possession; he chooses the former, as in other days and countries he might have chosen the latter. But when I went on to express surprise that he should regard himself as crazy, he repudiated this and said that by 'mental' and 'insane' he didn't mean that at all, he was very far from considering himself mad. Another patient, who spoke both languages, called his condition in English 'some obsessional trouble', but in German he called it 'Verfolgungswahn'. Into the patient's verbal expression of his attitude to his condition will enter all the modifying influences familiar in Aussage-psychology and in psycho-analytic studies.

But it is not only to his verbal expression we will pay heed; we will observe his demeanour and see how far it corroborates or gives the lie to his statements.

It is to his total attitude, possibly over a long period, and not to his verbal statements or his so-called intellectual acceptance of a point of view that we pay attention.

To summarize the modifying factors above alluded to is not easy. Nor are they only those familiar in Aussage-psychology or psycho-analytic studies. That would be to accept the view that the whole of disturbed mental function is describable in terms of so-called normal or more properly healthy functions.

In any mental disorder, whether mild or severe, continued or brief, alien or comprehensible, it is with his whole disordered mind that the patient contemplates his state or his individual symptoms, and in this disorder there are disturbances which are different from the healthy function either in degree, combination or kind. The hysteric brings to bear on his symptoms, or on his whole illness, a hysterical mind, not a healthy mind with a limited separable disturbance; in such a condition as a Ganser syndrome, the necessity for this view is evident. The obsessional brings his repetitive self-torturing mind to bear on his condition and his individual symptoms. The schizophrenic, the manic or depressive patient, the general paralytic, all contemplate their apprehensive change with that disturbed mind which we subdivide into disturbed memory, disturbed thinking, disturbed affectivity, disturbed perception, disturbed will or what not. The emphasis may lie more on one than another disturbed function, but always there will be a disturbance which makes it impossible for the patient to look at his data and judge them as we, the dispassionate, presumably healthy outsiders do. His judgments and attitude can therefore never be the same as ours because his data are different, and his machine for judging is different in some respects. You will see that if one undertakes to discuss insight in schizophrenia, say, in any detail, one must consider not only data of change in this condition, but also the whole psychopathology of schizophrenia, especially where it enters into the judgment of reality. All questions of the judgment of reality, such as are often introduced into the consideration of insight, go to the root of the psychopathology of different conditions and it is not possible to discuss them here.

You will also see that statements about a person with some mental disorder having 'complete insight' are loose and almost extravagant, except as clinical shorthand. If it be said that they are approximations and that a verbal concordance with the physician's or the unaffected comparable layman's opinion about the disorder is all that has been required, or that "a rough notion of the patient's sanity of judgment, or common-sense attitude towards his illness, is all one wants", well and good. But it must be recognized that that is no more than convenient clinical practice and has only qualified right of admission into psychopathology.

I have been so remiss in giving any of the clinical material or particular investigations on which my views rest that I should like now to make slight

amend by a few purely clinical observations. An eminent English psychiatrist has said that insight is an absolutely infallible and subtle touchstone for distinguishing neurosis from psychosis. Since I regard this distinction between neurosis and psychosis as false in principle and sometimes misleading in practice, I should not examine the use of insight in making it if I did not find the view so often the parent of confusion to beginners in psychiatry. They stumble over insight and then ask posers about whether something is not 'really psychotic' or 'only a neurosis'. It is I think correct to say that gross disorders of insight are often found in neuroses – to use the familiar word. The obsessional's attitude towards his illness or to any special symptoms is vastly different from that of his wife, or his friend, or his doctor: and one must, like Stoddart, narrow down insight to a mere question of delusion and coherence of thought, if one is going to say that the obsessional's insight is complete. As for the hysteric – who would suppose that a girl with dermatitis artefacta has a healthy or normal attitude towards her symptom? the same may be said of the man with a 'shell shock' tremor, or of any other of the manifold exhibitors of hysterical illness. Similarly with patients whose anxiety is extreme. If on the other hand one considers the familiar psychoses – schizophrenia and the affective group – one often finds a relatively good insight, in the usual clinical usage of the term. Thus in a patient with severe acute mania, whose record I selected at random, I found the following statements, "You see, I haven't been sleeping very well, that's sheer excitement you know, and, I went to my bath, I was shoebathed by my father. I am muddled. I've got such a lot to think about. I want to do a tremendous lot on very little. There's no time like the present. I'm a bit nervous, of course I am, examination, pulling yourself to bits". Another recurrent manic patient said, " I am hot, hot, strong... beware, where. Don't know what I'm doing again ... Have to keep on, oh the numbers. Have to keep on, one to be ready, two to be steady, three to be off ... You're going too quickly now, you're going too slowly now, look out... the answer is three words, don't be silly, don't be absurd. You're saying it too quickly. Oh Lord I'm awful ... I've lost my own self. I feel it in my chin. Don't look at me so hard, don't, listen. To listen you've got to stop yourself. Didn't I tell you, you've got to tread on it. Oh you fool, and using the bull. The wrong end of the stick I've got hold of it, you are a fool today". Deron, among several instances in his monograph on mania, quotes Mlle Et. who, after expressing her satisfaction at the great activity of her mind, added "Je ne suis pas normale, je pense tout haut". On the other hand I had a depressed patient who talked a lot, and continually commented on her own loquacity, *e.g.* "I was talking all night. I'm like a clock. I stop for a while and then I start again". As regards depressive states I may quote here from an investigation published elsewhere, which I made into a number of such patients. Of sixty-one, selected at random, twenty declared or

even protested that they were not ill, that there was no need whatever for them to be in hospital; nine said they had physical ailments but not mental or nervous ones; eighteen conceded illness but would not discuss its nature, and fourteen considered they had some mental or nervous disorder. But such figures in themselves mean little. One patient said "I'm not ill. My nerves are very strong, it's not nerves", and she also said "Perhaps I'm a little mad, hadn't I better be put in an asylum?"; another said "There isn't really anything the matter with me", but also "I wonder if I shall get all right again"; another "I'm not ill, I just have this nervous breakdown"; another "I didn't come here as a patient", yet almost in the same breath she added "I imagined things"; another "I'm not ill at all, there's nothing wrong with me", and yet also "I must be daft"; still another, "It's not illness but I am afraid I'll lose my reason".

A statement "I must be mad" or "I ought to be an asylum" is, however, not necessarily evidence of good insight: it may rest on characteristic disturbances of affect, severe anxiety, self-reproach; and is not far from the other interpretation, offered by one of these patients, "It's not illness but sin, or perhaps possession". One may get such convoluted statements as "The whole truth is, the brain's all right but the nerves aren't. I haven't any control over it. I feigned I was mad. It's an imaginative complaint, hysteria", or "My head's gone wrong but I am sane enough to talk of it. I ought to be killed like a mad dog". Sometimes in depressed patients a clear and painful insight takes the place of some illusion with which they have lived happily, and their judgment of themselves as well as of their present state has nothing to controvert it except the limiting effect upon their daily activity. I am tempted to go into details of depressed patients' attitudes towards individual symptoms, especially delusion, but it is recorded elsewhere.

Similarly the clinical aspects of insight in schizophrenia call for most detailed consideration, such as I must deny myself in this paper. The phenomenological studies into this disorder contain many arresting examples of insight. It is moreover, the common experience of psychiatrists that, at the onset of the disorder, the insight of the patient is sometimes considerable and is associated with a struggle against the illness that is tragic. Here is an account written by a boy of 18 years who has had a definite schizophrenic illness for at least a year; he has much depersonalization also. He writes:

I am more and more losing contact with my environment and with myself; instead of taking an interest in what goes on and caring about what happens with my illness, I am all the time losing my emotional contact with everything, including myself: what remains is only an abstract knowledge of what goes on around me and of the internal happenings in myself ... Even this illness which pierces to the centre of my whole life I can regard only objectively. But on rare occasions I am overwhelmed with the sudden realization of the ghastly

destruction that is caused by this creeping uncanny disease that I have fallen a victim to ... My life has something unreal, strangely unnatural about it now ... This dead emotionless attitude towards myself is almost as though I were protecting my nature against myself. With the numbing of my feelings I am as though half drugged: only in the rare accesses of anxiety I awake from this dream life and with torturing clearness I become aware of my actual state ... My despair sometimes floods over me. But after each such outburst I become more indifferent. I lose myself more in the disease, I sink into an almost oblivious existence. My fate when I reflect upon it is the most horrible one can conceive of. I cannot picture anything more frightful than for a well-endowed cultivated human being to live through his own gradual deterioration, fully aware of it all the time. But that is what is happening to me.

I should like to quote briefly from a record of another schizophrenic patient, who showed very well the changes in insight that can occur within the space of a single interview. He said:

I thought I heard voices saying always the same thing, wondering whether I was a Jew, or whether I was a fool. It worried me. There have been days lately when I have felt these voices. I seem to hear some sort of a voice in the distance calling. I have often thought they were obsessions, that I had thought myself into it: that I was looking out for the voices. I could never really realize ... My nerves were in such a bad state that I really could not, what shall I say, couldn't find the mental background to force these obsessions out of my head. I think I'd call it 'Verfolgungswahn' ... I thought people from the boat had come along and told that story that I was a Jew and I was a fool. I never knew whether that was an obsession of mine or whether it actually existed ... This morning I felt as if I was hypnotized ... The man in the next bed. I thought it was him and then I thought he had changed completely, then I thought "Oh yes it is", but in a minute I thought "No it couldn't be...". My illness is purely mental. I got into such a nervous state. I got terribly sensitive to outside influences. I feel the voices throb through my brain.

A few minutes later in the middle of a conversation about banking – he was a banker – he asked me if I had heard someone call out "Otto" just then, asked me if I was a police doctor; his appearance changed greatly, he appeared frightened and dejected and said, "I had a terrible feeling, I thought my mother was dead. I heard a voice say in my ear 'Mother'". Asked if there was anything in it really, he answered, "No, I just got that impression. I do get these funny sort of feelings, sometimes".

A few minutes later in great agitation he said, "I want to give myself up to the police at once, I feel I am not safe, I'll not leave this house alive".

And here we have at brief intervals a considerable change in the immediate data associated with a change of attitude. It is closely connected with the primary

uprush of beliefs, with immediate convictions – autochthonous ideas, such as Wernicke described and to which Targowla has recently devoted an interesting monograph *L'intuition delirante*. It would be going too far afield to discuss the factors which effect the change of attitude. But what is seen here, in the moments of what one would call clinically 'more insight', can be regarded as indicating a retrospective attitude towards recent morbid data. This question of retrospective insight is of great importance clinically, since upon it often depend questions of recovery and further prognosis. Willis, over a century ago, said that no one could be regarded as healthy until he voluntarily acknowledged his aberration. Such a view is still widely held not only with regard to schizophrenia but also to depressive states, paranoid ones, toxic confusional episodes and others. It has repeatedly been pointed out that such a general view is not justified, but it has sufficient truth in many cases to ensure its continuance, though sometimes harsh and cruel results follow its application. Neither the true clinical state of affairs, nor the psychopathology of retrospective insight can be gone into now. I have made investigations into it in affective states which I may later be able to communicate.

Omitting the complicated issues that arise in organic psychoses – and who can deny that they will be complicated when it is considered that aphasia enters into them, the very emblem of much-explored obscurity – omitting these and any discussion of the remarkable material which states of depersonalization offer, I would close these prolegomena with a reference to a common assumption that is not entirely justified. The bearing of insight on treatment has been stressed by many. It has been maintained that where there is good insight, psychotherapy is likely to be successful and the converse is held also to obtain. But the patients who complain most of their symptoms, or have the most 'objective' attitude towards them, are by no means those who co-operate best, or, co-operating, ride into harbour. Far be it from me at this hour to lay down criteria for successful psycho-therapy, but one might say in the most general way that defective insight in itself is no criterion for this purpose, and may be even the sign of an attitude towards health, a turning away from the evidence of ill-health, a repudiation of disease, which is an advantage in treatment. In such issues, however, as turn on the patient's willingness to come into hospital or to stay there, his insight may be an important, and even a determining factor.

As is perhaps clear from my little clinical orgy at the end, I have imposed a reluctant self-denial on myself in the earlier theoretical part of this paper. Such self-denial seemed necessary if the basis for any clinical study of insight was to be stated within the limits of a paper along the general lines that appear to me indispensable. I should be the last to suggest for these views finality or completeness.