SMIAdviser
A Clinical Support System for Serious Mental Illness

MYTH vs FACT on Serious Mental Illness

CHARACTER

There are many myths around serious mental illness (SMI) that are not accurate. Let's take a look at common myths around the character of individuals who have SMI.

MYTH	FACT
Individuals Who Have SMI Lack Insight About Their Conditions	Studies show that about half of people who have psychotic disorders lack insight about their illnesses to some degree. This is known as anosognosia. However, we know that this lack of insight is now viewed as more of a multidimensional, dynamic process. It is not simply a neurocognitive deficit.[1] The views that individuals have about their illnesses are shaped by social and cultural factors. These can change over time. Mental health professionals should see this issue as more than simply a need to educate patients about their conditions. You can best address insight through a dialogue that probes a range of factors that may affect how a person understands their condition.[2]

MYTH	FACT
Individuals Who Have SMI Cannot and Should Not Make Decisions for Themselves	Individuals who have SMI are far more informed than they were a few decades ago. Yet they still are often left out of decision making about their physical and mental health.[3] This can cause people who have SMI to feel frustrated and undervalued by the mental health care team. They may not feel like they have adequate - if any - input into their treatment plan and targeted outcomes. We can do better and should do better. Decision-making capacity is impaired in only a subset of individuals who have SMI.[4] This may change over time and depends on a person's emotional state. Clinicians have an ethical obligation to let people have a role in choices around their physical and mental health care.[5] Shared decision making strengthens the therapeutic relationship and builds trust and understanding. All meetings between the care team and individual who have SMI should account for the two experts in the room. One is the clinical team. They are experts who have knowledge about treatment choices and the evidence that informs those options. The other is the individual. They know best their own goals, supports, and history. Together they should develop a treatment plan that represents the results of their shared decision making. This plan should be shared with the whole treatment team and revisited on a routine basis.

MYTH	FACT
Individuals Who Have SMI are Prone to Violence	This is a harmful myth that contributes to stigma around SMI. It leads to a false public perception that equates criminality with SMI and other mental health conditions.[6] However, data do not support this perception. Overall, people who have SMI are much more likely to be victims of violent crime than perpetrators. There is some risk for violence linked with schizophrenia,[7] yet most of the excess risk for violence is linked to: ✔ co-occurring substance use disorders[7,8,9] ✔ violence that occurs before the start of treatment[10] ✔ treatment non-adherence[9]

2%
Annual rate of violent behavior for the general population[11]

2%
Annual rate of violent behavior for individuals who have SMI and no history of violent victimization, exposure to violence, or co-occurring disorders[11]

25%
Annual rate that people who have SMI are victims of violent crime each year[12]

11.8x higher
Likelihood for someone who has SMI to be the victim of a violent crime, compared to the general public[12]

Join our #MissionForBetter at SMIadviser.org.

Sources:
1. Gilleen J, Greenwood K, David AS. Anosognosia in schizophrenia and other neuropsychiatric disorders: similarities and differences. The Study of Anosognosia. Edited by Prigatano GP. New York, Oxford University Press, 2010.
2. Belvederi Murri M, Amore M. The Multiple Dimensions of Insight in Schizophrenia-Spectrum Disorders. Schizophr Bull. 2019 Mar 7;45(2):277-283. doi: 10.1093/schbul/sby092. PMID: 29939361; PMCID: PMC6403083.
3. Huang C, Plummer V, Lam L, Cross W. Perceptions of shared decision-making in severe mental illness: An integrative review. J Psychiatr Ment Health Nurs. 2020 Apr;27(2):103-127. doi: 10.1111/jpm.12558. Epub 2019 Dec 6. PMID: 31444919.
4. Palmer BW, Dunn LB, Appelbaum PS, Jeste DV. Correlates of treatment-related decision-making capacity among middle-aged and older patients with schizophrenia. Arch Gen Psychiatry. 2004 Mar;61(3):230-6. doi: 10.1001/archpsyc.61.3.230. PMID: 14993110.
5. Ganzini L, Volicer L, Nelson WA, Fox E, Derse AR. Ten myths about decision-making capacity. J Am Med Dir Assoc. 2004 Jul-Aug;5(4):263-7. doi: 10.1097/01.JAM.0000129821.34622.A2. PMID: 15228638.
6. Ghiasi N, Azhar Y, Singh J. Psychiatric Illness And Criminality. [Updated 2021 Apr 30]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK537064/
7. Fazel S, Gulati G, Linsell L, Geddes JR, Grann M. Schizophrenia and violence: systematic review and meta-analysis. PLoS Med. 2009 Aug;6(8):e1000120. doi: 10.1371/journal.pmed.1000120. Epub 2009 Aug 11. PMID: 19668362; PMCID: PMC2718581.
8. Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry. 2009 Feb;66(2):152-61. doi: 10.1001/archgenpsychiatry.2008.537. PMID: 19188537.
9. Witt K, van Dorn R, Fazel S. Risk factors for violence in psychosis: systematic review and meta-regression analysis of 110 studies. PLoS One. 2013;8(2):e55942. doi: 10.1371/journal.pone.0055942. Epub 2013 Feb 13. Erratum in: PLoS One. 2013;8(9). doi:10.1371/annotation/f4abfc20-5a38-4dec-aa46-7d28018bbe38. PMID: 23418482; PMCID: PMC3572179.
10. Large MM, Nielssen O. Violence in first-episode psychosis: a systematic review and meta-analysis. Schizophr Res. 2011 Feb;125(2-3):209-20. doi: 10.1016/j.schres.2010.11.026. Epub 2011 Jan 5. PMID: 21208783.
11. Swanson JW, McGinty EE, Fazel S, Mays VM. Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. Ann Epidemiol. 2015 May;25(5):366-76. doi: 10.1016/j.annepidem.2014.03.004. Epub 2014 Apr 29. PMID: 24861430; PMCID: PMC4211925.
12. Teplin LA, McClelland GM, Abram KM, Weiner DA. Crime victimization in adults with severe mental illness: comparison with the National Crime Victimization Survey. Arch Gen Psychiatry. 2005 Aug;62(8):911-21. doi: 10.1001/archpsyc.62.8.911. PMID: 16061769; PMCID: PMC1389236.

GRANT STATEMENT
Funding for SMI Adviser was made possible by Grant No. SM080818 from SAMHSA of the U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, SAMHSA/HHS or the U.S. Government.

An APA and SAMHSA Initiative

AMERICAN PSYCHIATRIC ASSOCIATION

SAMHSA Substance Abuse and Mental Health Services Administration