

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 treatment¹⁰
- ✔ treatment non-adherence⁹

2%

Annual rate of violent behavior for the general population¹¹

2%

Annual rate of violent behavior for individuals who have SMI and no history of violent victimization, exposure to violence, or co-occurring disorders¹¹

25%

Annual rate that people who have SMI are victims of violent crime each year¹²

11.8x higher

Likelihood for someone who has SMI to be the victim of a violent crime, compared to the general public¹²

Sources:

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