National Alliance on Mental Illness

Anosognosia

When someone rejects a diagnosis of mental illness, it's tempting to say that he's "in denial." But someone with acute mental illness may not be thinking clearly enough to consciously choose denial. They may instead be experiencing "lack of insight" or "lack of awareness." The formal medical term for this medical condition is anosognosia, from the Greek meaning "to not know a disease."

When we talk about anosognosia in mental illness, we mean that someone is unaware of their own mental health condition or that they can't perceive their condition accurately. Anosognosia is a common symptom of certain mental illnesses, perhaps the most difficult to understand for those who have never experienced it.

Anosognosia is relative. Self-awareness can vary over time, allowing a person to acknowledge their illness at times and making such knowledge impossible at other times. When insight shifts back and forth over time, we might think people are denying their condition out of fear or stubbornness, but variations in awareness are typical of anosognosia.

What Causes Anosognosia?

We constantly update our mental image of ourselves. When we get a sunburn, we adjust our self-image and expect to look different in the mirror. When we learn a new skill, we add it to our self-image and feel more competent. But this updating process is complicated. It requires the brain's frontal lobe to organize new information, develop a revised narrative and remember the new self-image.

Brain imaging studies have shown that this crucial area of the brain can be damaged by schizophrenia and bipolar disorder as well as by diseases like dementia. When the frontal lobe isn't operating at 100%, a person may lose—or partially lose—the ability to update his or her self-image.

Without an update, we're stuck with our old self-image from before the illness started. Since our perceptions feel accurate, we conclude that our loved ones are lying or making a mistake. If family and friends insist they're right, the person with an illness may get frustrated or angry, or begin to avoid them.

Anosognosia affects 50% of people with schizophrenia, and 40% of people with bipolar disorder. It can also accompany illnesses such as major depression with psychotic features. Treating these mental health conditions is much more complicated if lack of insight is one of the symptoms. People with anosognosia are placed at increased risk of homelessness or arrest. Learning to understand anosognosia and its risks can improve the odds of helping people with this difficult symptom.

Why Is Insight Important?

For a person with anosognosia, this inaccurate insight feels as real and convincing as other people's ability to perceive themselves. But these misperceptions cause conflicts with others and increased anxiety. Lack of insight also typically causes a person to avoid treatment. This makes it the most common reason for people to stop taking their medications. And, as it is often combined with psychosis or mania, lack of insight can cause reckless or undesirable behavior.

See more at: https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Anosognosia

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Bipolar Disorder

Bipolar disorder is a chronic mental illness that causes dramatic shifts in a person's mood, energy and ability to think clearly. People with bipolar disorder have high and low moods, known as mania and depression, which differ from the typical ups and downs most people experience. If left untreated, the symptoms usually get worse. However, with a strong lifestyle that includes self-management and a good treatment plan, many people live well with the condition.

Although bipolar disorder can occur at any point in life, the average age of onset is 25. Every year, 2.9% of the U.S. population is diagnosed with bipolar disorder, with nearly 83% of cases being classified as severe. Bipolar disorder affects men and women equally.

Symptoms

A person with bipolar disorder may have distinct manic or depressed states. Severe bipolar episodes of mania or depression may also include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood.

Mania. To be diagnosed with bipolar disorder, a person must have experienced mania or hypomania. Hypomania is a milder form of mania that doesn't include psychotic episodes. People with hypomania can often function normally in social situations or at work. Some people with bipolar disorder will have episodes of mania or hypomania many times; others may experience them only rarely.

Although someone with bipolar may find an elevated mood very appealing—especially if it occurs after depression—the "high" does not stop at a comfortable or controllable level. Moods can rapidly become more irritable, behavior more unpredictable and judgment more impaired. During periods of mania, people frequently behave impulsively, make reckless decisions and take unusual risks. Most of the time, people in manic states are unaware of the negative consequences of their actions.

Depression. Depression produces a combination of physical and emotional symptoms that inhibit a person's ability to function nearly every day for a period of at least two weeks. The level of depression can range from severe to moderate to mild low mood, which is called dysthymia when it is chronic.

Causes

Scientists have not discovered a single cause of bipolar disorder. They believe several factors may contribute:

- **Genetics.** The chances of developing bipolar disorder are increased if a child's parents or siblings have the disorder. But the role of genetics is not absolute.
- **Stress.** A stressful event such as a death in the family, an illness, a difficult relationship or financial problems can trigger the first bipolar episode. In some cases, drug abuse can trigger bipolar disorder.

- **Brain Structure.** Brain scans cannot diagnose bipolar disorder in an individual. However, researchers have identified subtle differences in the average size or activation of some brain structures in people with bipolar disorder. While brain structure alone may not cause it, there are some conditions in which damaged brain tissue can predispose a person.

Diagnosis

To be diagnosed with bipolar illness, a person has to have had at least one episode of mania or hypomania. *The Diagnostic and Statistical Manual of Mental Disorders* (DSM) defines four types of bipolar illness:

- **Bipolar I Disorder** is an illness in which people have experienced one or more episodes of mania. Most people diagnosed with bipolar I will have episodes of both mania and depression, though an episode of depression is not necessary for a diagnosis. To be diagnosed with bipolar I, a person's manic or mixed episodes must last at least seven days or be so severe that he requires hospitalization.
- **Bipolar II Disorder** is a subset of bipolar disorder in which people experience depressive episodes shifting back and forth with hypomanic episodes, but never a full manic episode.
- **Cyclothymic Disorder or Cyclothymia,** is a chronically unstable mood state in which people experience hypomania and mild depression for at least two years. People with cyclothymia may have brief periods of normal mood, but these periods last less than eight weeks.
- **Bipolar Disorder "other specified" and "unspecified"** is diagnosed when a person does not meet the criteria for bipolar I, II or cyclothymia but has had periods of clinically significant abnormal mood elevation.

Treatment

Bipolar disorder is a chronic illness, so treatment must be ongoing. If left untreated, the symptoms of bipolar disorder may get worse, so diagnosing it and beginning treatment in the early stages is important. There are several well-established types of treatment for bipolar disorder:

- **Medications,** such as mood stabilizers, antipsychotic medications and antidepressants
- **Psychotherapy,** such as cognitive behavioral therapy and family-focused therapy
- **Electroconvulsive therapy (ECT)**
- **Self-management strategies and education**
- **Complementary health approaches** such as meditation, faith and prayer

See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder

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Depression

Depression is more than just feeling sad or going through a rough patch. It's a serious mental health condition that requires understanding and medical care. Left untreated, depression can be devastating for the people who have it and for their families. Fortunately, with early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and lifestyle choices, many people do get better.

Some people have only one episode in a lifetime, but for most people depression recurs. Without treatment, episodes may last a few months to several years.

An estimated 16 million American adults—almost 7% of the population—had at least one major depressive episode in the past year. People of all ages and all racial, ethnic and socioeconomic backgrounds experience depression, but it does affect some groups of people more than others. Women are 70% more likely than men to experience depression, and young adults aged 18–25 are 60% more likely to have depression than people aged 50 or older.

Symptoms

Just like with any mental illness, people with depression experience symptoms differently. But for most people, depression changes how they function day-to-day. Common symptoms of depression include:

- Changes in sleep
- Changes in appetite
- Lack of concentration
- Loss of energy
- Lack of interest
- Low self esteem
- Hopelessness
- Changes in movement
- Physical aches and pains

Causes

Depression does not have a single cause. It can be triggered, or it may occur spontaneously without being associated with a life crisis, physical illness or other risk. Scientists believe several factors contribute to cause depression:

- **Trauma.** When people experience trauma at an early age, it can cause long-term changes in how their brains respond to fear and stress. These brain changes may explain why people who have a history of childhood trauma are more likely to experience depression.
- **Genetics**. Mood disorders and risk of suicide tend to run in families, but genetic inheritance is only one factor.
- **Life circumstances**. Marital status, financial standing and where a person lives have an effect on whether a person develops depression, but it can be a case of "the chicken or the egg."

- **Brain structure**. Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation.
- **Other medical conditions.** People who have a history of sleep disturbances, medical illness, chronic pain, anxiety, and attention-deficit hyperactivity disorder (ADHD) are more likely to develop depression.
- **Drug and alcohol abuse.** Approximately 30% of people with substance abuse problems also have depression.

Diagnosis

To be diagnosed with depression, a person must have experienced a major depressive episode that has lasted longer than two weeks. The symptoms of a major depressive episode include:

- Loss of interest or loss of pleasure in all activities
- Change in appetite or weight
- Sleep disturbances
- Feeling agitated or feeling slowed down
- Fatigue
- Feelings of low self-worth, guilt or shortcomings
- Difficulty concentrating or making decisions
- Suicidal thoughts or intentions

Treatments

Although depression can be a devastating illness, it often responds to treatment. The key is to get a specific evaluation and a treatment plan. Treatment can include any one or combination of:

- **Medications** including antidepressants, mood stabilizers and antipsychotic medications
- **Psychotherapy** including cognitive behavioral therapy, family-focused therapy and interpersonal therapy
- **Brain stimulation therapies** including electroconvulsive therapy (ECT) or repetitive transcranial magnetic stimulation (rTMS)
- **Light therapy,** which uses a light box to expose a person to full spectrum light and regulate the hormone melatonin
- **Exercise**
- **Alternative therapies** including acupuncture, meditation, and nutrition
- **Self-management strategies and education**
- **Mind/body/spirit approaches** such as meditation, faith, and prayer

See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Depression

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Schizophrenia

Schizophrenia is a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is a complex, long-term medical illness, affecting about 1% of Americans. Although schizophrenia can occur at any age, the average age of onset tends to be in the late teens to the early twenties for men, and the late twenties to early thirties for women. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.

Symptoms

Just like with any mental illness, people with schizophrenia experience symptoms differently. Symptoms include:

- Hallucinations, which can include a person hearing voices, seeing things, or smelling things others can't perceive.
- Delusions, which are false beliefs that don't change even when the person who holds them is presented with new ideas or facts.
- Disorganized thinking, such as struggling to remember things, organize thoughts or complete tasks.
- Anosognosia, which means they are unaware that they have an illness.
- Negative symptoms, such as being emotionally flat or speaking in a dull, disconnected way.

Causes

Research suggests that schizophrenia may have several possible causes:

- **Genetics**. Schizophrenia isn't caused by just one genetic variation, but a complex interplay of genetics and environmental influences. While schizophrenia occurs in 1% of the general population, having a history of family psychosis greatly increases the risk. Schizophrenia occurs at roughly 10% of people who have a first-degree relative with the disorder, such as a parent or sibling.
- **Environment.** Exposure to viruses or malnutrition before birth, particularly in the first and second trimesters has been shown to increase the risk of schizophrenia. Inflammation or autoimmune diseases can also lead to increased immune system
- **Brain chemistry.** Problems with certain brain chemicals, including neurotransmitters called dopamine and glutamate, may contribute to schizophrenia. Neurotransmitters allow brain cells to communicate with each other. Networks of neurons are likely involved as well.
- **Drug use.** Some studies have suggested that taking mind-altering drugs during teen years and young adulthood can increase the risk of schizophrenia. A growing body of evidence indicates that smoking marijuana increases the risk of psychotic incidents and the risk of ongoing psychotic experiences. The younger and more frequent the use, the greater the risk. Another study has found that smoking marijuana led to earlier onset of schizophrenia and often preceded the manifestation of the illness.

Diagnosis

Diagnosing schizophrenia is not easy. The difficulty of diagnosing this illness is compounded by the fact that many people who are diagnosed do not believe they have it. Lack of awareness is a common symptom of people diagnosed with schizophrenia and greatly complicates treatment. To be diagnosed with schizophrenia, a person must have two or more of the following symptoms occurring persistently in the context of reduced functioning:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms

Treatment

With medication, psychosocial rehabilitation and family support, the symptoms of schizophrenia can be reduced. People with schizophrenia should get treatment as soon as the illness starts showing, because early detection can reduce the severity of their symptoms. Treatment options include:

- **Antipsychotic medications.** Typically, a health care provider will prescribe antipsychotics to relieve symptoms of psychosis, such as delusions and hallucinations. Due to lack of awareness of having an illness and the serious side effects of medication used to treat schizophrenia, people who have been prescribed them are often hesitant to take them.
- **Psychotherapy** such as cognitive behavioral therapy (CBT) or cognitive enhancement therapy (CET).
- **Psychosocial Treatments.** People who engage in therapeutic interventions often see improvement, and experience greater mental stability. Psychosocial treatments enable people to compensate for or eliminate the barriers caused by their schizophrenia and learn to live successfully. If a person participates in psychosocial rehabilitation, they are more likely to continue taking their medication and less likely to relapse. Some of the more common psychosocial treatments include assertive community treatment (ACT).

See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia

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BALANCING NEEDS

Caring for Myself and My Ill Loved One; LEARNINGS ABOUT MUTUALITY

We learn in NAMI Family to Family class that our family members deserve and need respect, gentleness, and hope. Also, we discuss our own needs for ease, respect and hope. Balancing those two may rarely be exactly precise. However, I have learned over time that there is a lot I can do to maintain the balance in a more sustainable way.

Even though our son was a young adult in college, and successfully transitioning to self-management when he was struck with his sudden illness, we finally began to comprehend that getting him stable was paramount to allowing him the usual freedom to develop self-determination as a young adult. We had hesitated to insist on compliance, thinking that unfairly infringed on his independence, though we were providing complete financial support. Eventually, my husband and I came to understand that, since we were providing love, food, shelter and financial support, we did have a right to expect certain **basic** requirements of our ill loved one. Mutuality is fair for all.

For us, finally, at 5 years into this multi-year journey, those **basic** requirements FOR US were:

1. See the doctor and the therapist regularly.
2. Do exactly what they say to do, regarding therapy, medications and lifestyle issues (do not fight them or use internet research to defy them).
3. Sign HIPPA forms, allowing us full participation in your care.
4. Allow a family member to accompany you on all physician (medication) appointments.
5. Allow a family member to set up and witness medication taking.

Each family must determine its own basic requirements. I do not mean to imply that any other family should choose ours. Determining and then insisting upon our basic requirements being part of the reciprocal relationship with our loved one helps us avoid both burn-out and resentment. Additionally, our willingness to insist on adherence to prescribed treatments may very well be the essential lifeline that our loved one needs, in order to ever stabilize.

Our hope is that our loved one will come to comply with our minimal expectations. There may be times that our loved one will be unwilling to comply. The family must, in such case, be prepared to withdraw whatever basic support they provide. Only put on the table something you are absolutely willing to withdraw. In other words, make no idle or empty threats. Do not warn about consequences which you know you will not follow through on.

As our son gradually stabilized and improved, we began to **add further expectations**. I thought of this as a process of approaching, under supervision and with a safety net, the adult level of responsibilities that he had attained before his illness. In other words, I tried to balance nudging and holding back, much as one does with any other phase of development of a person: sometimes it is important to allow “resting on one’s laurels” and consolidating the growth. And then sometimes it is important to nudge to the next level of capacity, sensing they may be ready for more responsibility, even if hesitant. Always with respect and compassion.

So, we **added expectations of other behaviors, gradually and as appropriate**:

1. Self-care and care of room/bathroom (keeping the room doors closed is very helpful in the early stages, until my loved one can assume consistent adherence to our house rules).

2. Effort for the benefit of the household (we began with one daily chore; then added more, one at a time, as appropriate).

3. Begin participating in the world by volunteering. When more stable, then move to part-time work, so that needs for rest and recovery can be met. Then, if ever appropriate, move to full-time work when able to meet that level of responsibility and maintain wellness. We found that our son started wanting to get money and work long before he could reasonably sustain regular and consistent volunteer work, even. We considered it to be a good sign of improvement, but we insisted on following a thoughtful and steady progression, so as to avoid any further experiences of being fired or failing.

4. Allow to pay own bills.

5. Move to self-management of meds and medical appointments.

Additional matters must also be addressed by many of us:

1. Is substance abuse part of the issue? If my loved one is not obviously endangering others, perhaps I can hold off on this aspect till mental illness gets addressed. If any other person is endangered (e.g., driving while impaired), then, morally, I must include the substance use as a basic condition to be addressed or I must find a way to limit the potential harm to self or others.

2. Is my family member excessively gregarious/restless/socializing or, conversely, isolated? I will want to find enticements for compliance with a curfew, or with setting a goal of contacting others (daily, phone, text, in person?)

Finally, we learned that enticing our son, rather than threatening, that rewarding behaviors we wanted to encourage rather than punishing behaviors we didn't prefer, was much more satisfying for ALL of us. Threats, punishments, withholding……feels bad to everyone. Enticement, rewards, encouraging….feels a bit more respectful. For example, we wanted him to attend the weekly Connections Support Group while we attended our Family Support Group, so we had a family outing for an inexpensive meal beforehand. We wanted him to attend the 8-week Peer-to-Peer class, so we paid him a modest stipend each week he went.

The difficulty may be in finding something motivating, even a little bit, for our loved one. Whatever a reward or motivator is for our loved one, it is easier and less demanding to leverage anything that a family can provide which our ill loved one wants, rather than dealing with a completely resistant ill person. Find a way to make gradual wellness and self-reliance a satisfying journey for all. Find a way to make Balanced Mutuality a consistent part of the family's interactions and relationship. Find a way for Recovery and well-being for all!