CLASS 2

ADDITIONAL RESOURCES

Diagnostic Criteria for Schizophrenia

A. **Characteristic symptoms:** Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- delusions
- hallucinations
- disorganized speech (e.g., frequent derailment or incoherence)
- grossly disorganized or catatonic behavior
- negative symptoms, i.e., affective flattening, alogia or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. **Social/occupational dysfunction**: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. **Duration:** Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. **Schizoaffective and Mood Disorder exclusion**: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no major depressive episodes or Manic Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. **Substance/general medical condition exclusion**: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Source: Diagnostic and Statistical Manual (DSM-V), American Psychiatric Association

Try to Imagine What it Must be Like to Suffer from the Brain Disease Called Schizophrenia

"Schizophrenia is a disease that strikes at the very core of what makes us all human. As the cloud of schizophrenia moves across an individual's horizon, it introduces a barrier between that person and the capacity to experience warmth, to see and think clearly, and to feel and express feelings. The symptoms of schizophrenia run across the entire gamut of capacities that characterize human behavior, cognition, and emotion: perception, thought, language, emotion, volition, and creativity. The capacity to perform these functions well is often replaced by strange and terrifying internal perceptions and experiences, feelings of estrangement, the sense that personal autonomy is being violated, and the sense that control over oneself has been lost. To an outsider, these experiences are often bizarre, frightening, and off-putting. To the person with schizophrenia and his or her family, they are frightening and depressing. The combination of public misconceptions and ignorance with intense internal suffering makes schizophrenia perhaps the most tragic of human illnesses."

Nancy Andreasen, M.D., Ph.D.

Source: Schizophrenia: From Mind to Molecule.

The Vicissitudes of Schizophrenia

No single symptom is found in all individuals, nor is any one individual burdened with all the various signs and symptoms of schizophrenia. It is now believed that "Schizophrenia" is actually a group of brain diseases, each with different causes, but with similar symptomatic brain dysfunctions:

Alterations of the Senses

Over-acuteness of perceptions: Particularly in the early part of the prodromal stage, there is a heightened sense of hearing, vivid sharpness of colors; objects tend to "shimmer" or faces are hideously transformed; stimuli flood in without any way to screen them from the senses; those afflicted are overwhelmed by everything they see and hear, they are flooded with memories from the past.

This initial hyper-sensitivity can feel euphoric at the beginning; it is often described as intensely religious, as if one is being touched by God or given sudden cosmic understanding of the universe.

Blunting of perceptions: More commonly occurs in the later stages of the illness; this is not a medication effect, but a symptomatic deadening of sensation and response described for many years before medications become available; can include blocking of feelings of physical pain.

Inability to Interpret and Respond

Fractured, incoherent input: For many, the "broken brain" cannot properly sort incoming stimuli and synthesize these visual, auditory, emotional messages into any coherent whole; like shattering a perfectly composed picture, the individual is coping with countless "pieces" of meaning which don't fit together in any rational way; many have difficulty concentrating and cannot watch movies and TV where sight, sound, plot, etc. must be simultaneously "tracked".

Distorted input means disconnected output (thought disorder): Responses of individuals with schizophrenia appear to be random and entirely disengaged from the rational flow of expected interaction; responses are frequently inappropriate, as if the person were experiencing a completely different event. Responses appear jumbled, giving rise to a broad range of symptoms called loosening of associations, concrete thinking, impairment of logic, and word salad.

Thought blocking occurs in 95 percent of cases and is often interpreted by the sufferer as "someone taking thoughts out of my head" (a cardinal symptom of schizophrenia). Ambivalence is also very common, as if the person is transfixed by exact opposites and is unable to resolve them or make a decisive step one way or the other.

Delusions and Hallucinations

Inner experience appears real: Given these vivid sensory experiences which are unmoored from any rational interpretation, delusions and hallucinations appear to form a logical and coherent pattern, and have an internal consistency; what looks "odd/bizarre" to us on the outside is perceived as totally real/true to the sufferer.

Delusions are false ideas held by the sufferer which cannot be corrected by reason: In most cases, sensory input is simply misinterpreted, often as a meaningful "signal", or it is imbued with special import. In delusions of reference, the individual believes that random events are directly related to him or her; these events are given dramatic personal significance and are integrated into complex patterns of special meaning. Another delusional belief is that one's thought are radiating out of the brain, or are being transmitted by radio or TV (thought broadcasting) or that thoughts are being put into one's brain (thought insertion). Both of these latter delusions are also cardinal symptoms of schizophrenia.

In paranoid delusions, sufferers become convinced they are being controlled by others, manipulated or "wired" in the brain by sinister forces; or they fear people are going to hurt and attack them. These fears are then "confirmed" by misinterpreting other cues. This closed system creates a self-fulfilling prophecy, which in turn serves to validate delusional beliefs.

Grandiose delusions are common—that individuals control the weather, the movement of planets, or that they are God, Jesus, the Virgin Mary or some exalted or important person. People may believe they can fly, or that they are immune from harm, and they act on these beliefs with predictably tragic consequences.

Hallucinations are the result of over-acute senses: Visual brightness and gross distortions of visual stimuli are common. In true hallucinations, the individual sees and talks to things which are not there at all. In this case, the brain "makes up what it hears, sees, feels, smells or tastes." These phenomena are entirely real to the person. Auditory hallucinations are by far the most common in schizophrenia and stand alone as a symptom most characteristic of the illness.

Voices occur most frequently when going to sleep; in the majority of cases, the voices are unpleasant, accusatory, and critical. Although less common, smell, touch and taste hallucinations do occur and are vividly experienced.

Distorted perceptions of body parts as being detached, of body disfigurement, of one's body merging with another body, of being outside one's body are familiar hallucinations which create an altered sense of self in schizophrenia.

Changes in Emotions (affect)

Early stage depression and mood fluctuation: Many who develop schizophrenia have a clearly defined episode of depression, crying, and despondency which at the time seems inexplicable to them; this period of depression can fluctuate with moods of euphoria, feelings of religious ecstasy, recriminations of guilt and pervasive fear.

Inability to empathize: Individuals in the grip of exaggerated feelings lose the capacity to assess the emotional state of someone else; this impaired ability to "read" emotions in others is a primary reason why many people with schizophrenia have trouble with social communications and forming friendships.

Shift from exaggerated feelings to lack of feeling (flat affect): By the time the illness is full blown, many sufferers lose the capacity to feel altogether. This emotional “dullness" may cause inappropriate emotional responses to a given situation; it more commonly involves the flattening or "blunting" of the whole range of emotional feeling—as if the emotions did not exist at all, or they can no longer be expressed. With this emotional "blankness" comes apathy, lack of drive, poverty of thought and speech

(negative symptoms). Again, this is not a medication effect; negative symptoms are products of the disease process itself.

Changes in Behavior

Changes in motor responses: Individuals feel they are "speeded up" or slowed down; awkwardness, clumsiness, stumbling is common; many show a significant decrease in spontaneity of movement, or they are troubled by uncontrollable tics and tremors.

Need for withdrawal from others: Getting away from people, remaining quiet for long periods of time, even becoming immobile, are customary ways that people with schizophrenia seclude themselves from over-stimulation. Catatonia and mutism are extreme versions of withdrawal.

Adoption of eccentric behaviors: Ritualistic movement patterns, bizarre gestures and body positions, obsessions and compulsions, parroting what others are saying (echolalia) and socially inappropriate behaviors all seem internally logical and meaningful to the sufferer, but very odd to the outside observer.

Lack of insight: The afflicted person is often not aware of the malfunctioning of his or her brain; the delusional systems appear to "explain" everything that is happening to them. People who are outside these subjectively "logical" experiences are often perceived as the ones who are disturbed because they cannot interpret these special events the way the sufferer does. Lack of insight is almost universal in this brain disease and in some cases persists for the entire duration of the illness.

"Imagine what it would be like to have the alterations of the senses, the inability to interpret incoming stimuli, the delusions and hallucinations, changes in bodily boundaries, emotions and movements that are described above. Imagine what it would be like to no longer be able to trust your brain when it told you something. . . Is it any wonder that people with this disease get depressed? Is it any wonder that they frequently feel humiliated by their own behavior? If a worse disease than schizophrenia exists, it has not come to light. . . Given the disordered brain function as a starting point, many persons with schizophrenia are heroic in their attempts to keep a mental equilibrium. And the proper response of those who care about the unfortunate persons with this disease is patience and understanding."

Impaired Awareness of Illness: Anosognosia

Treatment Advocacy Center Briefing Paper

Summary: Impaired awareness of illness (anosognosia) is a major problem because it is the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. It is caused by damage to specific parts of the brain, especially the right hemisphere. It affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder. When taking medications, awareness of illness improves in some patients.

Impaired awareness of illness is a strange thing. It is difficult to understand how a person who is sick would not know it. Impaired awareness of illness is very difficult for other people to comprehend. To other people, a person's psychiatric symptoms seem so obvious that it's hard to believe the person is not aware he/she is ill. Oliver Sacks, in his book *The Man Who Mistook His Wife for a Hat*, noted this problem:

> It is not only difficult, it is impossible for patients with certain right- hemisphere syndromes to know their own problems ...And it is singularly difficult, for even the most sensitive observer, to picture the inner state, the 'situation' of such patients, for this is almost unimaginably remote from anything he himself has ever known.

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What is impaired awareness of illness?

Impaired awareness of illness means that the person does not recognize that he/she is sick. The person believes that their delusions are real (e.g. the woman across the street really is being paid by the CIA to spy on him/her) and that their hallucinations are real (e.g. the voices really are instructions being sent by the President). Impaired awareness of illness is the same thing as lack of insight. The term used by neurologists for impaired awareness of illness is anosognosia, which comes from the Greek word for disease (nosos) and knowledge (gnosis). It literally means "to not know a disease."

How big a problem is it?

Many studies of individuals with schizophrenia report that approximately half of them have moderate or severe impairment in their awareness of illness. Studies of bipolar disorder suggest that approximately 40 percent of individuals with this disease also have impaired awareness of illness. This is especially true if the person with bipolar disorder also has delusions and/or hallucinations.

Is this a new problem? I've never heard of it before.

Impaired awareness of illness in individuals with psychiatric disorders has been known for hundreds of years. In 1604 in his play *The Honest Whore*, playwright Thomas

Dekker has a character say: "That proves you mad because you know it not." Among neurologists, unawareness of illness is well known since it also occurs in some individuals with strokes, brain tumors, Alzheimer's disease and Huntington's disease. The term anosognosia was first used by a French neurologist in 1914. However, in psychiatry impaired awareness of illness has only become widely discussed since the late 1980s.

Is impaired awareness of illness the same thing as denial of illness?

No. Denial is a psychological mechanism which we all use, more or less. Impaired awareness of illness, on the other hand, has a biological basis and is caused by damage to the brain, especially the right brain hemisphere. The specific brain areas which appear to be most involved are the frontal lobe and part of the parietal lobe.

Can a person be partially aware of their illness?

Yes. Impaired awareness of illness is a relative, not an absolute problem. Some individuals may also fluctuate over time in their awareness, being more aware when they are in remission but losing the awareness when they relapse.

Are there ways to improve a person's awareness of their illness?

Studies suggest that approximately one-third of individuals with schizophrenia improve in awareness of their illness when they take antipsychotic medication. Studies also suggest that a larger percentage of individuals with bipolar disorder improve on medication.

Why is impaired awareness of illness important in schizophrenia and bipolar disorder?

Impaired awareness of illness is the single biggest reason why individuals with schizophrenia and bipolar disorder do not take medication. They do not believe they are sick, so why should they? Without medication, the person's symptoms become worse. This often makes them more vulnerable to being victimized and committing suicide. It also often leads to rehospitalization, homelessness, being incarcerated in jail or prison and violent acts against others because of the untreated symptoms.

Source: www.treatmentadvocacycenter.org

"David's Story"

An Excerpt from Private Terror/Public Life
by James M. Glass

It's like all my cells are exploded over the universe, and I live in each of those millions and millions of nuclei shooting in every direction. In the midst of all this, how could I possibly deal with the concrete, even tie my shoelaces, much less find my shoes?

I convinced myself several things were happening: Unrecognizable voices invaded my ears; transmitters had been planted in the ceiling; everyone on the Hall spoke about me; my behavior was watched and discussed by staff; nursing reports, patients' journals, were filled with hundreds of pages describing my appearance and movements; spies were sent into the Hall exclusively to keep track of me and to report any suspicious behavior to the hospital administration; therapists ignored their own patients and spent hours in endless discussion, looking at the ramifications of my case; TV cameras, hooked into the walls taped my facial expressions; every morning, around 3 a.m., three thousand spotlights aimed directly into my eyes; staff prepared elaborate strategies to humiliate me, to expose me and leave me naked in front of the Hall; killers hid behind closed doors and waited until night to sneak into my room; food poisoned my insides and rotted out my intestines. Lying down, my body became so brittle I felt it cracking into a thousand pieces; at night, my roommate fed on my blood. Not exactly sane thoughts. In my frame of mind, if I were to stay alive, I had to be attuned to every movement on the Hall.

I hear this voice sometimes. I call it the "maelstrom of manufactured criticism" because it always tears away at me, rips my identity into shreds, and slices away at everything I am. It's like being in the midst of the Straits of the Sirens with a ferocious storm overhead, no sun, just black clouds that turn the world into night. Sometimes the voice booms in my ears. Other times, it sounds like a song, a melody, but the lyrics, even though the singing is sweet, are filled with criticism and attack. The verbal abuse never lets up. It goes on and on for hours. Nothing outside touches me when it's there: I refuse to talk to anyone; I sit, stare, smoke cigarettes until the voice leaves.

Nothing really stops the madness. I rarely change clothes; hygiene and meals become too much. And I have more important things to do than be bothered with my nutrition or cleanliness. Contact with people seems closed off; I lose interest in what happens on the Hall. I forget what day it is; I lose track of mealtimes and Hall meetings. Something as simple as selecting a shirt paralyzes me. That's what begins my psychotic episodes, little things, nothing more dramatic than trying to find a shirt. It's like this huge problem overtakes you: moving toward the closet, opening the door, searching through the rack. Each step of the process is like climbing Mount Everest, so you say to yourself, "Why bother, let it be, stay with the one on your back." Little things are magnified a thousand times, and what happens inside your mind takes on much greater importance than your own hygiene or appearance.

Women and Depression

Clinical depression affects two to three times as many women as men, both in the U.S. and in many societies around the world. It is estimated that one out of every eight women will suffer from clinical depression in her lifetime. Women also experience higher rates of seasonal affective disorder and dysthymia (chronic depression) than men. While the rate of bipolar disorder (manic depression) is similar in men and women, women have higher rates of the depressed phase of manic depression and women are three times more likely to experience rapid-cycling bipolar disorder.

What causes the higher rate of depression in women?

The explanation for the gender gap in susceptibility to depression most probably lies in a combination of biological, genetic, psychological, and social factors.

Biological factors: There appear to be important links between mood changes and reproductive health events. Gender differences in rates of depression emerge when females enter puberty and remain high throughout the childbearing years and into late middle age. Hormonal factors seem to play a role in some of the mood disturbance experienced by women. Twenty to 40 percent of menstruating women experience premenstrual mood and behavioral changes. Approximately 2 -10 percent of women experience Premenstrual Dysphoric Disorder, a severe form of premenstrual syndrome that is characterized by severely impairing behavior and mood changes. As many as 10 - 15 percent of women experience a clinical depression during pregnancy or after the birth of a baby. There also appears to be an increase in depression during the perimenopausal period, but after menopause, this does not appear to be the case. Differences in thyroid function between men and women may also contribute to the gender difference in the prevalence of mood disorders.

Another biological factor that may contribute to gender differences in depression can be linked to circadian rhythm patterns, the complex system that regulates sleep and activity over each 24- hour period. Depressed women report more hypersomnia (excessive sleeping) than do men. Gender differences in the activity of neurotransmitters including serotonin and the effects of estrogen on theses neurotransmitters may also be linked to the gender disparity in rates of depression.

Genetic factors: Some forms of depression run in families. There is a 25 percent rate of depression in the first-degree relatives (mother, father, siblings) of people with depression and greater prevalence of the illness in first-degree and second-degree female relatives. But depression also occurs in people who have no family history of the disease. The genetic contribution to risk for depression is not something specific to women. Men and women from families with depression are both at greater risk than those who come from families with no depression.

Psychosocial factors: Psychosocial factors that may contribute to women's increased vulnerability to depression include the stress of multiple work and family responsibilities, sexual and physical abuse, sexual discrimination, lack of social supports, traumatic life experiences and poverty.

Psychological make-up plays an important role in one's vulnerability to depression as well. Thus, individuals with low self-esteem, pessimistic views and tendencies towards stress are prone to clinical depression.

Studies also indicate that sexual and physical abuse are major risk factors for depression. Women are twice as likely as men to have experienced sexual abuse. A recent study found that three out of five of the women diagnosed with depressive illnesses had been victims of abuse. In one major study, 100 percent of women who had experienced severe childhood sexual abuse developed depression later in life.

Does pregnancy influence depression?

Although it once was thought that women experienced low rates of mental illness during pregnancy, recent research reveals that over 10 percent of pregnant women and approximately 15 percent of postpartum women experience depression. As many as 80 percent of women experience the "postpartum blues," a brief period of mood symptoms that is considered normal following childbirth. However, the related hormonal and biological changes associated with pregnancy or giving birth may initiate a clinical depression. Or, the changes in lifestyle associated with caring for a young infant may constitute a set of stressors that have mental health consequences for the mother. There is a three-fold increase in risk for depression during or following a pregnancy among women with a history of mood disorders. Once a woman has experienced a postpartum depression, her risk of having another reaches 70 percent.

One woman in a thousand experiences a postpartum psychosis – a medical emergency in which the woman may inflict harm upon herself and/or her baby. The first episode of bipolar disorder in women frequently occurs following the birth of a child.

Source: NAMI Fact Sheet on Depression. This link will take you to the page on the NAMI Web site to the new NAMI Women and Depression brochure.
http://www.nami.org/Content/ContentGroups/Helpline1/FINALWomensDepressionBrochure.pdf

Criteria for Major Depressive Episode: DSM 5

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

Source: DSM-V, American Psychiatric Association

Darkness Visible: A Personal Account of Depression

Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self—to the mediating intellect—as to verge close to being beyond description. It thus remains nearly incomprehensible to those who have not experienced it in its extreme mode, although the gloom, 'the blues' which people go through occasionally and associate with the general hassle of everyday existence are of such prevalence that they do give many individuals a hint of the illness in its catastrophic form. But at the time of which I write I had descended far past those familiar, manageable doldrums…

It was not really alarming at first, since the change was subtle, but I did notice that my surroundings took on a different tone at certain times: the shadows of nightfall seemed more somber, my mornings were less buoyant, walks in the woods became less zestful, and there was a moment during my working hours in the late afternoon when a kind of panic and anxiety overtook me, just for a few minutes, accompanied by a visceral queasiness—such a seizure was at least slightly alarming, after all.

I felt a kind of numbness, an enervation, but more particularly an odd fragility—as if my body had actually become frail, hypersensitive and somehow disjointed and clumsy, lacking normal coordination. And soon I was in the throes of a pervasive hypochondria. Nothing felt quite right with my corporeal self; there were twitches and pains, sometimes intermittent, often seemingly constant that seemed to presage all sorts of dire infirmities. . .

It was October, and one of the unforgettable features of this stage of my disorder was the way in which my own farmhouse, my beloved home for 30 years, took on for me at that point when my spirits regularly sank to their nadir an almost palpable quality of ominousness. The fading evening light— akin to that famous 'slant of light' of Emily Dickinson's, which spoke to her of death, of chill extinction—had none of its familiar autumnal loveliness, but ensnared me in a suffocating gloom… That fall, as the disorder gradually took full possession of my system, I began to conceive that my mind itself was like one of those outmoded small town telephone exchanges, being gradually inundated by flood waters: one by one, the normal circuits began to drown, causing some of the functions of the body and nearly all of those of instinct and intellect to slowly disconnect…

What I had begun to discover is that, mysteriously and in ways that are totally remote from normal experience, the gray drizzle of horror induced by depression takes on the quality of physical pain. But it is not an immediately identifiable pain, like that of a broken limb. It may be more accurate to say that despair, owing to some evil trick played upon the sick brain by the inhabiting psyche, comes to resemble the diabolical discomfort of being imprisoned in a fiercely overheated room. And because no breeze stirs this cauldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion.

Source: William Styron, Darkness Visible, NY: Random House

Criteria for Manic Episode: DSM 5

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- inflated self-esteem or grandiosity
- decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
- more talkative than usual or pressure to keep talking
- flight of ideas or subjective experience that thoughts are racing
- distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
- increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The mood disturbance is sufficiently severe to cause marked impairment In occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Source: DSM-V, American Psychiatric Association

The Experience of Manic-Depressive Illness

A Personal Account

There is a particular kind of pain, elation, loneliness, and terror involved in this kind of madness. When you're high it's tremendous. The ideas and feelings are fast and frequent like shooting stars and you follow them until you find better and brighter ones. Shyness goes, the right words and gestures are suddenly there, the power to seduce and captivate others a felt certainty. There are interests found in uninteresting people. Sensuality is pervasive and the desire to seduce and be seduced irresistible.

Feelings of ease, intensity, power, wellbeing, financial omnipotence, and euphoria now pervade one's marrow. But, somewhere, this changes. The fast ideas are far too fast and there are far too many; overwhelming confusion replaces clarity. Memory goes. Humor and absorption on friends' faces are replaced by fear and concern.

Everything previously moving with the grain is now against—you are irritable, angry, frightened, uncontrollable, and enmeshed totally in the blackest caves of the mind. You never knew those caves were there. It will never end.

Madness carves its own reality. It goes on and on and finally there are only others' recollections of your behavior—your bizarre, frenetic, aimless behaviors—for mania has at least some grace in partially obliterating memories. What then, after the medications, psychiatrist, despair, depression and overdose? All those incredible feelings to sort through. Who is being too polite to say what? Who knows what? What did I do? Why? And most hauntingly, when will it happen again? Then, too, are the annoyances—medicine to take, resent, forget, take, resent and forget, but always to take. Credit cards revoked, bounced checks to cover, explanations due at work, apologies to make, intermittent memories of vague men (what did I do?), friendships gone or drained, a ruined marriage. And always, when will it happen again? Which of my feelings are real? Which of the me's is me? The wild, impulsive, chaotic, energetic, and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one? Probably a bit of both, hopefully much that is neither. Virginia Woolf, in her dives and climbs, said it all: "How far do our feelings take their color from the dive underground? I mean, what is the reality of any feeling?"

Source: Frederick K. Goodwin, M.D., and Kay Redfield Jamison, Ph.D., Manic- Depressive Illness. NY: Oxford University Press.

National Alliance on Mental Illness

Disparities in Mental Health Treatment among GLBT Populations

The history of mental health treatment of gay, lesbian, bisexual, and transgender (GLBT) populations is an uneasy one. In the 1950s and 60s, many psychiatrists believed that homosexuality (as well as bisexuality) was a mental disorder. Gay men and lesbians were often subjected to treatment against their will, including forced hospitalizations, aversion therapy, and electroshock therapy.

Fortunately, there have been great strides made in the nearly 35 years since the American Psychiatric Association removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders*, or the DSM. Despite this, there are still disparities and unequal treatment among some GLBT groups seeking care.

Mental Health Treatment and GLBT Populations

In the past 35 years, the attitudes of mental health professionals have shown a positive change toward GLBT populations. For example, a 2005 study found that **58% of psychologists supported a gay-affirmative stance in therapy,** compared to only 5% in 1991.[1]

Despite these positive changes in attitudes, however, many mental health professionals still report a lack of focus on GLBT issues in their training. For example, a survey of therapists-to-be found that **even though they had positive attitudes about GLB populations, they generally felt unprepared to counsel GLB clients**, and many programs lacked coursework or training modules on GLB issues.[2]

Nevertheless, recent studies suggest that gay, lesbian, and bisexual populations are actually more likely to report using therapy or counseling than heterosexual groups.[3] Upon reflection, this is not so surprising given the stressors that GLBT groups must confront, such as homophobia, societal discrimination and prejudice, coming out, and negotiating family relationships.

There are still disparities, though, in both mental health research and services when it comes to certain GLBT populations, including:

- Racial and ethnic minorities
- Rural populations
- Bisexual people
- Transgender people
- People with serious mental illness

Racial and ethnic minorities

To date, most research on GLBT populations has been done with predominantly white samples. The mental health issues and needs of GLBT persons of color, therefore, are still largely unknown and vastly understudied.[4,5]

What we **do** know, however, is that GLBT African American, Latino, Native American, Asian Pacific Islander, and other racial and ethnic minorities share at least one thing: **they must confront racism as well as homophobia**. These multiple levels of oppression and the experience of being a minority within a minority may contribute to an increased vulnerability to mental illness, particularly depression and anxiety.[5]

In addition to these issues, there is the reality that people of color are underrepresented in mental health professions. For example, while African Americans comprise about 12% of the population, only 2% of psychologists and 4% of social workers are African American. This lack of representation in the field of mental health providers may contribute to an underutilization of mental health services among racial and ethnic minorities in general, and may also mean that for GLBT people of color seeking mental health treatment, there are even fewer culturally component resources available.

Rural populations

Not all GLBT persons live in big cities. For GLBT persons living in rural areas, there may be a number of barriers to finding GLBT-friendly mental health providers and programs.[6,7] In a study of mental health providers serving two

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rural communities, participants reported widespread anti-GLBT bias and an overall lack of resources for GLBT persons. Unfortunately, fears of harassment — or worse — prevented GLBT *providers* from working with GLBT consumers to create networks and resources.[7]

Bisexual people

Bisexual people continue to be overlooked in mental health research and may often confront stereotypes when seeking therapy or other mental health services. They may also face rejection from the larger heterosexual community *as well as* from gay and lesbian communities.

When working with bisexual clients, it is important for mental health professionals to recognize that for many, a bisexual identity is a legitimate identity and does not represent confusion or lack of a commitment to a gay (or straight) identity. Mental health providers should not assume that bisexuality is the presenting issue. Rather, they should take their cues from the client and proceed accordingly.[8]

Transgender people

The relationship between gender identity and the field of mental health is a complicated issue that cannot be done justice in a few paragraphs. However, too often it is the case that people who are gender-variant, or whose gender does not conform to their birth sex, face the most severe discrimination and maltreatment in *most* settings, including healthcare settings.[9]

As transgender people become more visible, it is important for providers to understand that **gender expression is not the same as sexual orientation** (transgender people often identify as straight). In addition, identifying as transgender **does not** automatically mean that someone has a mental illness.[10]

People with serious mental illness

To date, most information we have about GLBT people and mental health is related to counseling or psychotherapy. There is little to no information about gay, lesbian, bisexual, and transgender people with serious mental illness or those who require services other than therapy. What little we do know, however, suggests that GLBT people with serious mental illness are often subjected to poor treatment, particularly in the public mental health system. They often feel compelled to hide their sexual orientation in an effort to protect themselves from ridicule or maltreatment from counselors, peers, and staff.[11]

Furthermore, those agencies specifically serving GLBT populations are often uneducated or unprepared to address the needs of those who have a serious mental illness.

Those in in-patient settings have also reported that attempting to negotiate unfriendly or blatantly homophobic settings can be quite taxing. Efforts to conceal a fundamental part of themselves — their sexual orientation or gender identity — can interfere with successful treatment, as GLBT people are not able to bring the entirety of who they are into treatment.[11]

Addressing Disparities

One key way to address these disparities is through GLBT cultural competency trainings for all persons working in the mental health professions. Cultural competence involves the *individual* and his or her attitudes, behaviors, and beliefs as well as the *institution* and its behaviors and policies. Individual cultural competence means that one can communicate effectively with people who are different. At the institutional level, it means that an agency is consciously set up to meet the needs of people from different cultures. It is only through education that we can begin to dismantle the barriers to care that many GLBT persons still confront.

For more information about general standards of practice in the provision of health care to GLBT populations go to: www.glbthealth.org/CommunityStandardsofPractice.htm

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Mental Health Issues among Gay, Lesbian, Bisexual, and Transgender (GLBT) People

National Alliance on Mental Illness

According to the National Institute on Mental Health, an estimated 26% of adults 18 and older, or 1 in 4 Americans, experience a mental illness in a given year.[1] Just like everyone else, gay, lesbian, bisexual, and transgender (GLBT) people also experience mental Illnesses.

First and foremost, however, we must remember that **being** gay, lesbian, bisexual, or transgender **is not** a mental illness in and of itself. Just because someone is GLBT doesn't automatically mean that they will experience a mental illness. According to the American Psychological Association:

"Homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities. Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations." [2]

However, GLBT people may face unique risks to their mental health and well-being, which mental health providers should be aware of.

Most research suggests that GLBT people are likely to be at higher risk for depression, anxiety, and substance use disorders.[3-5] One study found that **GLB groups are about two-and-one-half times more likely than heterosexual men and women to have had a mental health disorder,** such as those related to mood, anxiety, or substance use, in their lifetime.[4]

In a national study comparing GLB and heterosexual groups, researchers found that gay and bisexual men were more likely to report major depression and panic disorder in the previous twelve month period. Lesbian and bisexual women were more than three times as likely to have experienced generalized anxiety disorder.[5]

The reason for these disparities is most likely related to the societal stigma and resulting prejudice and discrimination that GLBT face on a regular basis, from society at large, but also from family members, peers, co-workers and classmates.

In terms of more serious mental illnesses, such as those that are long-term and require hospitalization or in-patient care, unfortunately we don't know very much. However, of the approximately 18 million people with serious mental illness, a reasonable estimate suggests that about 720,000 are gay, lesbian, bisexual, or transgender.[6]

In one of the few studies of serious or major mental illness among GLBT people, researchers found that LGB men were less likely to report psychotic disorders, such as schizophrenia, but more likely to report mood disorders, such as depression and bi-polar disorders. They found no differences between GLBT and heterosexual women.[7]

A note on terminology

The term "GLBT" is commonly used as shorthand for the *gay, lesbian, bisexual*, and *transgender* community. It is important to note that while these groups may share some similarities, they are by no means identical in terms of their mental health issues, concerns, or needs.

While the terms *lesbian*, *gay*, and *bisexual* (and *heterosexual*) refer to someone's *sexual orientation*, ***transgender*** is a term related to gender identity, or someone's sense of being a man or woman, boy or girl. Transgender people are heterosexual, gay, lesbian, and bisexual.

The term ***gay*** typically refers to a man who is romantically and emotionally attracted to other men.

Lesbian (or gay woman) refers to a woman who is romantically and emotionally attracted to other women.

Bisexual refers to someone who is romantically and emotionally attracted to men and women. Being bisexual does not necessarily mean someone is involved in multiple relationships at once.

Some men and women may engage in same-sex behavior yet still identify as heterosexual, and some lesbian or gay people may have sexual relationships with people of the other sex. It is important not to make assumptions or judge people when it comes to sexual orientation and gender identity.

Finally, GLBT people are just as diverse as everyone else! We are old, young, rich, poor, parents, children, friends, co-workers, Latino, African American, and on and on. Just like people with mental illness, GLBT people are everywhere and in every community!

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Special Considerations

Dual or Double Stigma

Mental illness is regrettably still stigmatized in our society. So, too, is being lesbian, gay, bisexual or transgendered. A GLBT person with mental illness may be in the unfortunate position, then, of having to contend with *both* stigmas. It is often the case that GLBT people experience a mental health care system that is not comfortable with or sensitive to issues related to sexual orientation, while the GLBT community is not sensitive to or educated about serious mental health issues.[8] This societal stigma can contribute to and exacerbate existing mental health problems.

Family Support

People with mental illness often rely on family for support.
However, for some GLBT people, families are not accepting of their sexual orientation or gender identity. In extreme cases, GLBT people are disowned or kicked out of their homes, which leaves them without an important source of support. Such situations may contribute to more vulnerability among this population, and they suggest just how important it is for GLBT people to have access to affirming, supportive, and culturally appropriate mental health services.[8]

Violence

The societal stigma and prejudice against GLBT people take many forms. Too often, they can take the form of verbal or physical violence. Experiences of violence can have significant and enduring consequences for mental health. A recent study found that 25% of GB men and 20% of LB women had experienced victimization as an adult based on their sexual orientation.[9] In turn, these groups also reported more symptoms of depression, anxiety, and post-traumatic stress. Mental health providers need to be aware of this issue and the potential negative effects it can have on GLBT peoples' mental health.

Internalized Homophobia

Homophobia refers to irrational fear or hatred of gay people. Sometimes, GLBT people turn society's negative view about them inward, or *internalize* it. This can affect psychological well-being and can have consequences for healthy development, particularly among youth.[10] Again, mental health providers need to be aware of this issue and how it may affect mental health and well-being among their GLBT clients and patients.

In sum, GLBT people **do not** by definition have a mental illness, but they have to contend with societal stigma and negative experiences that likely contribute to an increased vulnerability to mental illness. It is important to note, however, that despite this, most GLBT people ultimately live happy and health lives!

Resources

GLBT National Hotline
1-888-THE-GLNH (843-4564)

Rainbow Youth Hotline
1-877-LGBT-YTH (1-877-542-8984)

LGBT Suicide Prevention Hotline
www.TheTrevorProject.org or 1-800-850-8078

NAMI
www.nami.org
1-800-950-NAMI (6264)

Parents, Families and Friends of Lesbians and Gays
www.pflag.org

American Psychological Association
www.apa.org/pi/lgbc/

Rainbow Heights Club
www.rainbowheights.org
Support and advocacy for LGBT mental health consumers (based in New

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National Alliance on Mental Illness

Double Stigma: GLBT People Living with Mental Illness

As anyone living with mental illness can confirm, in our society there are still stigma and prejudice associated with mental illness. In fact, some people may refuse to seek professional help to avoid the stigma it might bring.[1]

As if this were not challenging enough, consider what it must be like to face mental illness as part of an additionally stigmatized group; in this case, as a gay, lesbian, bisexual, or transgender (GLBT) person. Unfortunately, this person must deal with a **double stigma.** Further, those who are living in poverty, have a disability, or are from communities of color may have multiple stigmas to contend with.

GLBT people must confront stigma and prejudice based on their sexual orientation or gender identity while also dealing with the societal bias against mental illness. The effects of this double or dual stigma can be particularly harmful, especially someone seeks treatment.

For example, some people report having to hide their sexual orientation from those in the mental health system for fear of being ridiculed, rejected, or in extreme cases, subjected to physical violence. On the other hand, when GLBT people with serious mental illness seek assistance from gay and lesbian organizations, these agencies are often not educated or knowledgeable about the full spectrum of mental illnesses and are ill-equipped to provide appropriate services.[2]

If people cannot be open and feel supported in who they are in a treatment setting, this will negatively affect their ability to benefit from the therapeutic experience. This is especially true for those confronted with double stigma.

It is important to remember, however, that double stigma is something that *society* creates. It is not the fault of the individual. To overcome stigma, we need to recognize it and work to change it. What are some of the ways that we can do this?

Providers at the Rainbow Heights Club, a Brooklyn-based program that serves GLBT people, suggest the following ways to overcome stigma:

- Think carefully about the labels applied to people, as labels can create further isolation and discrimination.
- Don't assume someone's sexual orientation or gender identity; also don't assume what their treatment needs are based on stereotypes of either GLBT people OR those living with mental illness.
- Empathize and validate GLBT persons' experiences.
- Recognize that discrimination exists for GLBT persons and can affect access to many resources.
- Work in coordination with people with mental illness rather than assuming that providers have all the answers.[4] (For more information: www.rainbowheights.org)

While it is imperative for society at large to dismantle stigma, many GLBT people with mental illness must still confront this double stigma in their daily lives. What are some ways to cope?

- Surround yourself with supportive people, such as family or friends or others who may be dealing with the same issues as you.
- Get appropriate treatment. Getting treatment may help you feel less isolated and to better understand your illness.
- Share your experiences with others. By breaking the silence, either about being GLBT, having a mental illness, or both, you can help people understand the issues involved with both.
- Join a political or advocacy group like NAMI. Sometimes joining forces with others to combat unjust policies or unfair treatment can be a productive way to cope with stigma.

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