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Inside Schizophrenia: Mending the Internal Conflict; And, The Historical, Cultural and Social Aspects of Schizophrenia

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Inside Schizophrenia: Mending the Internal Conflict

And

The Historical, Cultural and Social Aspects of

Schizophrenia

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USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

Abstract:

This thesis comprises a memoir and essay on schizophrenia. It is estimated that 285,000 people suffer some form of schizophrenia in Australia. This means, on average, one in seventy people in Australia suffer from the disorder. For males, schizophrenia often develops in early adulthood. For females, it has later onset. There are about five types of schizophrenia: paranoid, catatonic, disorganised, undifferentiated, and residual. The focus of this thesis is on the diagnosis of Paranoid Schizophrenia. There is no cure, but it is treatable. However, people with a treatment resistant schizophrenia can find life difficult. The aim of the thesis is to inform people that it is not a condition to fear, and to dispel the stigma often associated with mental illness. Many people shy away from schizophrenics, as the impression given by media is that schizophrenics are dangerous. Another common myth is that schizophrenics have 'split personality', which is not the case. The symptoms do not involve multiple personalities. Schizophrenia derives from the Greek, meaning 'split mind', and this is where the myth has originated.

The focus of the essay is on the historical, cultural and social aspects of schizophrenia. The term schizophrenia was coined in the early twentieth century. The essay looks at ancient texts, where schizophrenia possibly originated in early forms of psychosis. It also considers other cultures, in many of which schizophrenia is stigmatized. Through demystification, the thesis aims to show that it is a medical complaint, rather than a spiritual one. Social aspects include the need for more community support for schizophrenics. This thesis will, hopefully, help to facilitate greater understanding of the condition by providing a personal perspective.

Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

a) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution or higher education;

b) contain any material previously published or written by another person except where due reference is made in the text; or

c) contain any defamatory material.

I also grant permission for the Library of Edith Cowan University to make duplicate copies of my thesis as required.

Fiona Erica Nichols

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Contents

The Historical, Cultural and Social Aspects of Schizophrenia

This essay will attempt to address a number of factors that accompany the debilitating brain disease, schizophrenia. What this paper intends is to give an insight into how schizophrenia is viewed historically, culturally and socially by Western Society and across the world. First of all, it is important to outline the nature of the disorder and what it comprises. According to a fact sheet produced by SANE, Australia (2010), '[s]chizophrenia is an illness, a medical condition. It affects the normal functioning of the brain, interfering with a person's ability to think, feel and act" (SANE, 2010, p 1.) However, it could be said that any form of brain disease interferes "with a person's ability to think, feel and act" and it is important to differentiate between this disorder and others.

First states that schizophrenia presents a mixture of characteristic signs, which are considered both positive and negative symptoms (according to the DSM –IV diagnostic chart). Positive symptoms are considered to be distortions or exaggerations of thinking (delusions). A sufferer's perception (hallucinations), and language can become disorganized with behavioural traits, which are also considered highly dysfunctional. Negative symptoms are considered to be emotional blunting, poverty of speech and an inability to initiate goal-oriented tasks (First, 1994, p274-277).

History of Schizophrenia

The word schizophrenia comes from the Greek roots Skhinzein "to split" and phren "mind", so translates as "split mind", but that does not mean that someone who suffers from the disease has a split mind. Popular beliefs led lay

people to think of schizophrenics as having a split or multiple personality, which is not the case. The person is in possession of their personality and never loses the sense of self. Frith & Johnstone postulate that most people have not had experience with someone suffering from a mental illness so what the lay man knows is limited to the popular press. They state that the media often concentrates on sensational stories that result in some form of violence. From such reports people get the impression that people who suffer from this disorder are, or can be, criminally insane (Frith & Johnstone, 2003, p. 1-2).

Historically speaking, schizophrenia is interesting, and, according to the Karolinska Institute, the disorder can be traced back as far as ancient Egypt some two thousand years before Christ. The Karolinska Institute assert that recent literature studies suggest that the Greeks had an understanding of psychosis but had no diagnostic criteria for it, as seen in today's medicine. According to The Karolinska Institute, Kraepelin defined schizophrenia as dementia praecox in 1887. He used this diagnosis of dementia to discern between those with manic depression and schizophrenia. His focus was particularly on schizophrenia as an early form of dementia, only seen in young people, rather than the form that most know today as Alzheimer's disease. A Swiss physician, Bleuler, coined the phrase schizophrenia in 1911, and was the first to talk about negative and positive symptoms. The Karolinska Institute states that Bleuler noticed that schizophrenia did not always lead to mental deterioration and was formed in all age groups (The Karolinska Institute, retrieved from http//www.schizophrenia.com 23/04/2012, p. 1).

Barham postulates that Swiss psychiatrists, Ciompi & Muller, had a great social vision for those afflicted with schizophrenia. These two physicians embarked on an investigation known as enquête de Lausanne, which has given a great deal of historical insight into the destinies of schizophrenic patients born between 1873 and 1897. Barham states that the lives of 228 schizophrenics were recorded over a thirty-seven year period from first hospital admission to re-examination and sometimes for much, much longer. According to earlier studies it was believed that schizophrenia was an unfavourable disease where people's quality of life deteriorated. Later studies, however, proved to be more promising, although the idea of schizophrenic deterioration was perpetuated until the late 1960s. People actually had the opportunity of improving. This can be liberating knowledge for those confronted with such a disorder. Barham states that the earlier forms of thought around schizophrenia failed to see that the disorder was in fact a brain disease and theorizes that Bleuler challenged conventional psychiatric thinking for his time. Moreover, the Swiss attitude to schizophrenia was more recovery based, as opposed to the British and American ways of thinking which, until the 1930s and in some cases even today, see the disease as having an 'incurability principle' (Barham, 1984, pp. 47-55).

Wallace & Gach postulate that schizophrenia is a relatively new disorder and refer to the earliest writings about the illness dated around 1856.

At that time, it was not known as schizophrenia and the term was coined in the early twentieth century by Bleuler. Wallace & Gach state that many look to the distant past to prove historical uniformity. They describe how Saddock refers to the disorder as early as 1400 BCE, using the Hindu document known as Ayur-

Veda. According to Wallace & Gach, the Ayur-Veda states that a man had a condition afflicted by devils which made him walk around in a filthy manner whilst naked, forgetting important details and in an uneasy gait. Wallace & Gach say that should not be disregarded as a set of symptoms but, to assume that the man was in psychosis is definitely presumptuous (Wallace & Gach, 2008, pp. 461-462). There is no doubt that the disease that we know today as schizophrenia was most likely around in the period before Christ, because many people had been seen as being afflicted by devils for hundreds of years before the disorder was categorized as a medical condition affecting the mind, rather than the spirit. Those who were unable to understand the bizarre behaviours of schizophrenia viewed it as a spiritual affliction, rather than a medical complaint. Medical science is relatively new and we are still in the process of making new discoveries.

What is conceived as a schizophrenic mindset varies across cultures, but that is not to say that a particular set of criterion does not exist for abnormal behaviour across cultures. Wallace & Gach mention the anthropologist, Jane M. Murphy and her work on the cross-cultural abnormalities that are present in schizophrenia, thus adding to the historical discourse available on the subject. Wallace & Gach state that "the cultures that Jane M. Murphy and other scholars of comparative medical anthropology have examined reflect different conceptual structures in organizing their understanding signs into comprehensible patterns" (Wallace & Gach, 2008, p. 462). They argue that these comprehensible patterns are central to the history of schizophrenia as a whole, which would only

exemplify how the disease has uniform characteristics, historically and culturally.

The argument about schizophrenia going back to the dawn of time does not interest the scholars Wallace & Gach. They view the beginning of schizophrenia as an historical entity when Bleuler reinterpreted "dementia praecox" and coined the term, which we have come to know today. They state that Bleuler changed the perception of dementia praecox to schizophrenia and the disorder was no longer viewed as a dementia of adolescents, as previously seen by the medical fraternity. Bleuler's reinterpretation of the disorder was ground breaking for 1911. Earlier points of view, particularly in the nineteenth century, saw that there were three forms of dementia: in adolescence, mid-life and old age. It was Bleuler's work that changed the adolescent and mid-life dementias into a different category all together.

Lavretsky, in Mueser & Jetse, states that Morel was the first to categorise the brain disorder as dementia praecox around 1809-1873. It was not until Kraepelin organised the disorder into a set of characteristics that a formulation for diagnosis began to be set. According to Lavretsky, in 1863 Kraepelin hypothesised that catatonia was a new characteristic that was found in the disease and, even today, people are known to have the diagnosis of catatonic schizophrenia, whereby a person can end up having little or no movement of limbs. In 1871, Hecker added to the discourse of the dementia praecox prototype, with his own list of characteristics formulating dementia paranoia, whereby patients often experienced auditory hallucinations, known today as

paranoid schizophrenia, which is undoubtedly one of the most commonly diagnosed schizophrenias.

Lavretsky postulates that the Kraepelinian diagnostic model is still strongly regarded by European and American Psychiatry, but the question remains: is it outdated? Today we are inclined to think that the idea of the illness being debilitating is outdated, but that the diagnostic criteria are still fairly sound. With the introduction of antipsychotics, more people afflicted by schizophrenia are leading productive and fulfilling lives, which was not the case previously. According to Lavretsky, Kraepelin's diagnostic criteria was rather complex and in 1959 the psychiatrist Schneider simplified the symptoms for diagnostic purposes. Schneider's criteria are as follows: "audible thoughts; arguing or commenting voices; feeling controlled or influenced by external force; thought withdrawal; diffusion of thoughts; and delusions" (Mueser & Jetse , 2008, p. 4). This seems to be the way of looking at schizophrenia in the early twenty-first century and serves as the diagnostic criteria for today's medical fraternity.

Lavretsky asserts that Bleuler, as mentioned earlier in this essay, was way ahead of his time. Bleuler saw schizophrenia in psychological terms, rather than in scientific terms and Lavretsky says that it has taken another hundred years of research since Bleuler coined the term schizophrenia, fully to assess his hypothesis. This appears to be sound, according to modern scientific theory. Lavretsky asserts that, viewing it as schizophrenia rather than dementia praecox, was revolutionary thinking for 1911. He chose the name schizophrenia

because, according to Lavretsky, it means "a mind that is torn asunder", aforementioned (Mueser & Jetse , 2008, p. 4).

Lavretsky states that there was limited treatment for those suffering from schizophrenia in the first half of the twentieth century and thousands of inpatients having the diagnosis were hospitalised indefinitely. Lavretsky informs us that the treatment for schizophrenia was started by accident, despite psychiatrists trying hard for years to come up with a cure. Laborit, a French surgeon was trialling a new drug called promethazine for circulatory shock after surgery, but found that it had sedating and euphoric effects on individuals. This in turn attracted the interest of researchers in the area of psychiatry. The drug was modified somewhat into what is currently known as chlorpromazine and appeared to have antipsychotic properties that proved useful in the treatment of patients with schizophrenia. Although a range of antipsychotic medication is now available, chlorpromazine is still the drug of choice for individuals with treatment resistant psychosis.

Despite improved treatment, the patient's integration back into society was still limited. If a patient stopped taking their medication, relapse was almost inevitable. Psychiatrists testify to the fact that many who suffer from schizophrenia live in poverty, and suffer from the stigma that the disorder attracts. Prior to the 1950s, the form of treatment was psychoanalysis and electroshock therapy, which proved to be quite futile. In the 1960s, cognitive behavioural therapy was developed and proved to be quite effective with those suffering from schizophrenia. This form of treatment, as well as life skills training, drastically improved the lifestyle of those suffering from the disorder,

and supportive work programmes were put in place to help outpatients work and integrate with society. So, according to Lavretsky, there is no 'one' treatment for schizophrenia that proves effective. Supportive services, such as psychology and psychiatry, are necessary in the successful treatment of the disorder.

Shives also postulates that traces from written accounts on schizophrenia go back as far as ancient Egypt, 200 BCE. She states that the Egyptians saw psychosis as a disease of the uterus and heart. According to Shives, the disease originated from blood vessels, fecal matter, poison and other things such as demons. Those suffering from demonic possession in the bible and during the medieval era were probably sufferers of schizophrenia or of some other brain disorder such as epilepsy. Shives asserts that Greek and Roman health saw paranoia and delusions as a sign of imbalance in the bodily humours. Hippocrates believed that insanity was a state induced by the liver, and it was not until the eighteenth century that people began to suspect that it had something to do with the central nervous system, which is closer to what we believe in modern times. These days we liken the disorder to being a problem associated with the brain and it would be interesting to find out what we might know about schizophrenia in a hundred years from now.

Shives does not claim any new insights into the Kraepelinian psychiatry but does mention that, when Bleuler coined the term schizophrenia in 1911, he organised the disorder into three major types, which are disorganised, catatonic and paranoid. Interestingly, Bleuler was the first to describe the positive and negative symptoms of schizophrenia. These three types of schizophrenia are still regarded in the modern diagnostic model, in addition to two others known as

residual and undifferentiated schizophrenias. It was in the nineteenth century that it was theorised that schizophrenia was a disease of the brain. Research in the twentieth century showed a strong link between genetics and the disorder. It is now theorized that the disorder is predominantly hereditary (Shives, 2008, pp.1-5).

Noll states that the disease was only recognised in 1809 but speculates that it probably goes back for hundreds, if not thousands, of years. He asserts that the concept of madness has been "reported on record in every society, no matter how ancient or how primitive" (Noll, 2007, p. ix). Interestingly, Noll is speaking about the term schizophrenia itself, rather than the disease being a new step in human evolution. Like Shives, Noll believes the link between schizophrenia and genetics to be strong. There has been an attempt to link schizophrenia to Babylonian times or Sanskrit texts, but Noll believes that the behaviours mentioned in the texts are obscured and that this documentation does not necessarily reflect mentions of mental illness. Noll states that, without being present to observe the behaviours that these texts mention, it is not possible to make a hypothesis. He believes that ancient texts include delusional and hallucinatory descriptions that could be attributed to other health complaints and this much is undoubtedly true, although he does suggest that the disease was probably around then due to its strong genetic predisposition (Noll, 2007, pp. ix-27).

Noll argues that this is particularly true of nineteenth- and twentieth-century anthropological descriptions of schizophrenia, whereby the cause of the disease could be from a brain injury, brain infection or stroke. It is possible that

the descriptions mentioned could be linked to bipolar disorder (manic depressive) psychosis or some other form of atypical psychiatric disorder. He says that the texts lack the data needed to diagnose an individual with schizophrenia, as the diagnosis is not freely given without some duration of symptoms. He argues that there could be other underlying reasons for these results (Noll, 2007, pp. ix-27).

Noll also asserts that psychiatrists, anthropologists and psychologists alike have suggested that Shamans or Magic Healers have some form of schizophrenia, which would explain their visions and trances. They further assert that having some special role set aside for them stops them from deteriorating like modern day schizophrenics. They believe that these behaviours would be otherwise regarded as schizophrenic in our society. This may well be true, but, as Noll suggests, there is a lack of documented evidence to formulate such an opinion. It indicates that anything out of the ordinary could be regarded as schizophrenic but this could be seen to be grasping at straws (Noll, 2007, pp. ix-27).

Noll reminds us that, with the seventeen hundreds, came the first 'madhouses' where people who were mentally ill were incarcerated away from the general populace and this spawned the first close observation of mental disorders over a period of time. Doctors who knew little about mental afflictions were starting to be in charge of these 'madhouses'. It was not until Sydenham, commonly known as the "English Hippocrates" that the idea of disease and a set of symptoms came about. Once this was observed, diseases began to become

categorised and the beginning of the modern medical fraternity was born (Noll, 2007, pp. ix-27).

Noll states that, since antiquity, people with psychosis were sent off in ships, flogged, caged or even sometimes just killed. Until the fifteen hundreds the care of the mentally ill had mainly been the province of monks and nuns. The oldest known asylum is Bethlam Royal Hospital (also known as "Bedlam"), which was first established in 1247, and by 1329 it functioned as a hospital. Interestingly, the concept of madness was formed in the seventeen hundreds. Doctors who treated such disorders were known as 'mad-doctors' or 'lunatic-doctors' and it was these physicians who began to classify the various symptoms of mental illnesses through observation of patients. If it had not been for the early work of these doctors we undoubtedly would not have the knowledge we have today of schizophrenia (Noll, 2007, pp.1x-27).

Haycock says that it is difficult to determine whether people in ancient societies suffered from schizophrenia. He, like so many other writers, referred to in this essay, could only go on documented evidence that has been collected over a specific time period. Early texts lack this advantage. Haycock states that, although it is possible to find descriptions of mental illness in early writings, the criteria needed to determine whether an individual suffered from schizophrenia is lacking. He asserts that the descriptions of the mentally ill in early texts are problematic or sketchy at best. In earlier times, people with schizophrenia may have been perceived as having mystic influence or connections to a higher power. Although some researchers suggest that mental illness may have existed

in the Middle Ages, Haycock disputes this, as there are no firm records to support the case (Haycok, 2009, pp. npn).

Although there are strong references to mental illness in Shakespearean plays, Haycock debates that what one person will see as schizophrenia another will see as different form of disease. Again, there is a lack of diagnostic criteria from the sixteenth century. Haycock seems to support Torrey's notion of schizophrenia being first documented in the early nineteenth century when physicians Haslam and Pinel described people as suffering from schizophrenic-like symptoms. In the second half of the nineteenth century, the idea of schizophrenia was emerging and labels with which psychiatrists are familiar today were starting to take form (Haycock, 2009, npn).

Haycock states that paranoid psychosis was first described in 1868, then disorganised schizophrenia in 1871, followed by catatonic schizophrenia in 1874. These disorders were thought to be different forms of mental illness until twenty years had passed and they were grouped together under the label of dementia praecox. In 1834, Russian author Gogol provided one of the most complete descriptions of someone suffering from schizophrenia in his short story entitled, "Diary of a Madman". His protagonist shows signs of schizophrenia through auditory hallucinations whereby dogs talk to each other, and delusions where the protagonist believes he is King of Spain (Haycock, 2009, npn).

Today, brain imagining and other tests suggest that there is some substantial evidence pointing toward brain damage as being a significant factor contributing to this disease. Haycock states that there are no strong findings that the disease

is the result of psychological problems, but these may be a contributing factor. However, from my point of view, I feel that it is necessary to pinpoint new research concerning hereditary factors of the disease. Recent reports suggest that there are nine genetic precursors to the disease, and that, out of those studied with the disorder, most showed signs of two or more precursors (The Karolinska Institute, retrieved from http//www.schizophrenia.com 23/04/2012, p. 1). If this scientific evidence proves to be correct then I believe that this should change our current opinions on the history of schizophrenia. If schizophrenia is in fact genetic, like Huntington's disease, this would surely indicate that the disorder has been around since the dawn of humankind and is therefore a very old condition that has gone unrecognised for thousands of years.

Current understanding of schizophrenia, according to scientific thought, is that it is a disorder that is brought about by the dopamine imbalance in the brain and little is known about why current antipsychotics work. Science suggests that the disorder may in fact be genetic and there is some evidence to suggest that trauma to those predisposed to the disorder can have an onset of schizophrenia or if drugs or alcohol are consumed in copious amounts this can increase the prevalence of this disorder. Although more is known about schizophrenia in the modern era, more research has yet to be conducted to yield better results.

Cultural Schizophrenia

Shayegan suffers from schizophrenia also and his opinion on the disorder reflects his culture. Shayegan states that schizophrenia is not just something that has simply influenced the writer but emanates from a whole network of causes, which has influenced their conceptualisation of the meaning of politics, from

school and the essence of the self. Despite being a sufferer of the disease, Shayegan has given a new voice to reason. So the question exists: what is it like for an Islamic schizophrenic in their society?

Shayegan states:

Casual untruth has infiltrated the texture of my ideas, it infects my deformed concepts, it smoulders in the inconsistency of my actions and follows me to the inner defences, becoming, in a sense my second nature. I am out of alignment with myself, and with what I am supposed to embody, and with what beckons me from all sides. I am racked between new ideas which evaporate for a lack of context and ancient ideas arthritic with a failure to adapt. Lying becomes a way of life, a way of apprehending a reality which evades me, which imposes repeated failures upon me, against which I am defenceless (Shayegan, 1992, p. 10).

So, even in Islamic culture, there seems to be a sense of disconnection from the general culture. Shayegan states that 'casual untruth has infiltrated the texture of my ideas' and this is not such a foreign concept to many Western schizophrenics. Schizophrenics are therefore divorced from societal constructs, regardless of culture. This challenges the notion of a "shared meaning", which Jenkins & Barrett explore in more detail.

Jenkins & Barrett offer an interesting opinion on schizophrenia and culture. They state that 'the construction of shared meaning, usually taken for granted, can become fraught in schizophrenia' (Jenkins & Barrett, 2003, p.30). The idea of reality is problematic. Shayegan finds it hard to conceptualise what is considered normal because of the diagnosis they suffer from (Shayegan, 1992, p.10). Jenkins & Barrett suggest that the '"edge of experience" is cut … ordinary and extraordinary, conventional and inverted, lucid and distorted, making schizophrenia a paradigm case for the broader elucidation of fundamental human processes' (Jenkins & Barrett, 2003, p.30). They postulate that those suffering from schizophrenia are fairly normal in most cases. This concept is interesting because it maintains that in each group there are patterns of behaviour or ideals that ring true for that particular group of individuals.

Jenkins & Barrett talk about the concept of basic human processes, and, in their opinion, this means that a particular culture would hold true to what is considered normal, which might differ from society to society. They state that the concept of normal and abnormal is seen in relation to fundamental and basic processes of the human condition. The question that exists is: if shared meaning creates a reality, what of the schizophrenic reality, which vastly differs from individual to individual? It is shallow to suggest that there is a shared meaning to everything when people perceive things differently, even if they do not suffer from schizophrenia. Therefore reality is subjective (Jenkins & Barrett, 2003 p.30). If reality is indeed subjective, regardless of whether an individual is schizophrenic or not, is it possible that environment affects the construction of

reality, which then becomes distorted by the schizophrenic mind? Swami, Furham, Kannan & Sinniah consider the Western model of nurture vs nature.

Swami, Furnham, Kannan & Sinniah suggest that Europeans have little understanding of schizophrenia and see the term as meaning a 'split personality', which is a problem I addressed previously. They also state that recent studies show a lack of understanding of the disorder. According to Swami et al, the West perceives schizophrenia as being more environmental than biological, and can be mostly brought on by recent stressors. In particular, life experiences are considered to be more the cause of schizophrenia in Western society and biological factors are deemed to be secondary (Swami, Furnham, Kannan & Sinniah, 2008, pp. 164-179).

Swami et al believe that non-Western civilisations have tended to attribute schizophrenia to supernatural phenomena, induced by witchcraft or evil spirits. Cross-cultural studies have concluded that non-Western societies view mental illness more negatively because of this attitude. It was suggested that the British concentrated more on the civil liberties of schizophrenics and viewed them as less dangerous when compared with the Japanese model. Japanese leant toward the belief that schizophrenia was stress induced, whereas the British saw it quite differently, favouring the biological model. Interestingly, despite improved mental health facilities in Malaysia, stigmatisation of those with mental health issues, no matter how mild, is prevalent in their society. Employers have been known to refuse opportunities to those with mental health issues, not unlike Australia. One early study showed that Malaysians saw the disorder schizophrenia as related to the supernatural yet in our society the idea

would not be contemplated. Rational thought would suggest that the paranormal has nothing to do with it (Swami, Furnham, Kannan & Sinniah, 2008, pp. 164-179).

It seems that the more religious the sub-group is within a society, the more they look toward supernatural causes for mental illness. Swami et al suggest that the Malays, who are predominantly Muslim, viewed schizophrenia in a negative supernatural light but that the Chinese and Kadazan-Dusuns, who are mainly Christian, do not see schizophrenia similarly. Swami et al say that there is a low level of understanding of schizophrenia and they think that a social-environmental model is the cause of the disorder rather than biological. There was little evidence to suggest that the Malaysian general public views sufferers of schizophrenia as dangerous, uncontrollable or even superstitious. In the belief that the social model of schizophrenia predominates, they think that the best way to treat the disorder is to change the environmental circumstances for those suffering from it. It could be true that schizophrenia is partially environmental, and Breen examines various environmental models for different ethnic groups.

Breen proposes a different view of schizophrenia and applies it to the Black and Jewish minorities. Breen states that '[t]he symptoms of schizophrenia are often seen as regressions to culturally universal, infantile modes of functioning' (Breen, 1968, p. 282). He proposes a different view from this, and asserts that he chooses to look at the exaggeration model, which means that 'the schizophrenic is not solely returning to earlier modes of coping with stress, but he is making exaggerated use of the defence systems which, in milder forms,

define aspects of mature personality of the culture in which he was raised' (Breen, 1968, p. 282). Breen asserts that much of the symptomology of paranoid schizophrenia can be seen as an exaggeration of normal processes, which I believe from my own experience to be the case. He says that maliciousness in the environment can cause these signs. I would also tend to agree with this statement, as the trigger for my own schizophrenic episode was a neighbour having ill intent toward me, which in turn induced paranoia as shown in my memoir. Breen states that '[t]his may not be unreasonable' because 'life is seen as a battle' by some societies (Breen, 1968, p. 282).

Opler & Singer, as outlined by Breen, lean toward the exaggeration model of schizophrenia. They propose that those suffering from schizophrenia in the American Irish and the American Italian populace would present signs that are regarded as an over-exaggeration of normal values from within that society. The American Italian schizophrenics are seen to be more expressive and impulsive, as emotional expressiveness in this culture is seen to be normal, and these signs are exaggerated. The Irish Americans are seen to be more withdrawn as a fantasy substitute is regarded as more common among those of that society. Breen states that, where there is an aggression-controlling culture, the dependency pattern in schizophrenics is more likely to present itself and in an aggression-expressing culture, the paranoid pattern is likely to exist (Breen, 1968, p. 282).

It is hypothesised by Breen (1968) that the African American culture is one of aggression-expressiveness and that the Jewish American culture is one of an aggression controlling nature. Breen (1968) states that the African

Americans often live a hard life and grow up in a less supportive environment, which means that the African American mother may view independence in her children as a virtue rather than as a sense of loss. Often a mother of this culture has an unstable marriage, is forced to work and cannot afford to give her children adequate attention. Corporal punishment toward children is disagreeable but seen as part of the natural order. A teenager in this culture may grow up to be independent, self-reliant and will often leave his family of origin with little upset. Hence a person who suffers a stress-induced psychosis leading to schizophrenia may in fact lean toward the paranoid model in order to survive (Breen, 1968, p. 285).

Breen also postulates that the Jewish American model presents the opposite. There is little violence in the family and the alpha female sees her identity as merely a mother. According to Breen, she may tend to smother her children and protect them from the outside world, which is advantageous to their schooling. However, the natural tendency toward independence in the teen years is met with disapproval, making it hard for children to explore sexual relationships. A mother would be reluctant to let her child go and the child is far less likely to move away from the family of origin, often bringing their own children up with the mother present. Whilst violence is not common among these families, guilt is often used as a tool to keep children in line when they might otherwise become too wilful. Often someone suffering from schizophrenia in this culture will be most likely diagnosed with hebephrenic or catatonic schizophrenia, tending toward the dependency model. Breen is, in essence, supporting the 'nurture' and environmental framework to explain schizophrenia.

While I believe that environment does play a role in the development of the disorder, there is also outstanding evidence pointing to its hereditary nature (Breen, 1968, p. 284). Interestingly, Kulhura & Advasthi & Grover & Sharan & Sharma & Malhorta & Gill show that in Indian culture cares for its schizophrenics in the home environment as opposed to the hospital environment, as in the West. Since nurture plays a large part, nurturing a schizophrenic in a home environment prevents them from becoming institutionalised as in the West. Breen's environmental models would thus be different for Indian schizophrenics.

Kulhara & Advasthi & Grover & Sharan & Sharma & Malhorta & Gill assert that '[i]n India the majority of patients with schizophrenia are cared for in the community …in the setting of the family to which they belong' (Kulhara & Advasthi & Grover & Sharan & Sharma & Malhorta & Gill, 2009, p. 810). In the West we rely a lot more on hospitals to give care to those with the brain disorder and such things as aged care. The Indian caregivers of such patients are heavily burdened and distressed. It is also a fair assessment to state that 95% of the cost of a schizophrenic patient in India is borne by the family. So, when assessing the needs and understanding of Indian people with schizophrenia, it is important to remember that the caregivers can shed a lot of light on the situation. This study was carried out on a number of schizophrenics who attended psychiatric services in Northern India.

Kulhara et al. assert that the patients studied showed high levels of dysfunction and are considered moderately to severely ill. They perceive that these patients have little or no social support but they do not outline the support that the schizophrenics receive from within the community. One of the

components lacking in India, according to Kulhara et al., is the lack of daytime activities put in place for the mentally ill. There is a great need for increased social benefits, which most Western countries have put in place. There are hardly any agencies to help with the needs of schizophrenic people in Indian society. Money seems to be a big problem for the caregivers of schizophrenics. India, with its booming population, needs to reflect some socialist values if life for the average schizophrenic there is going to improve. However, there is a problem of work shortage for a growing population, and it is probably not possible for the schizophrenic to find suitable employment in this disadvantaged nation, in any case (Kulhara & Advasthi & Grover & Sharan & Sharma & Malhorta & Gill, 2009, p. 810). This, of course, may change if India becomes a first world country.

Kulhara et al. suggest that there is little support from the Nation, but the support of the caregiver is great (Kulhara & Advasthi & Grover & Sharan & Sharma & Malhorta & Gill, 2009, p. 811). Fewer schizophrenics are abandoned and left to their own devices, as they are in Western countries. It appears that, in the West, less community support is given and therefore it is difficult for the schizophrenic sufferers to seek out help. Dr. Koloth, who is Indian and was once my medical professional, told me that there are whole communities of schizophrenic people in India who live together and help each other out. This is unheard of in the West and many are socially isolated. As schizophrenics are treated in hospitals mainly in the West it could be said that this leads to further social isolation which may not be there in the Indian model.

Social Aspects of Schizophrenia

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Weinberger & Harrison assert that '[s]ocial disadvantage in the course of schizophrenia is not a consequence of the disorder alone' (Weinberger & Harrison, 2011, npn). They suggest that '[i]n most cases of schizophrenia social disability becomes manifest with accumulating negative symptoms and increasing cognitive impairment long before the first psychiatric contact' (Weinberger & Harrison, 2011, npn). Weinberger & Harrison believe that social development is impaired if the onset of schizophrenia occurs at a younger age and that it can remain stagnant if untreated. They also believe that a later onset, where there is a high level of social development, can lead to social decline. On average, the onset of schizophrenia in women is four years later than in men, meaning that females may have achieved such things as a successful marriage, employment and education. They can therefore be less handicapped than men. Population studies suggest that men with an earlier onset of schizophrenia are much more likely to suffer from drug/alcohol abuse, self-neglect, aggressive behaviour and poor socio-cultural integration. The women who suffer the disorder show more social integration than their male counterparts, who can exhibit poor medication compliance. Weinberger & Harrison suggest that there is a definite link between medication compliance and social wellbeing.

While protective oestrogens are only with women until menopause, women see a greater decline in their social functioning at a later age while, with men, adverse social decline is lessened with age. Weinberger & Harrison postulate that poor social integration is caused by a preexisting lack of functioning, cognitive impairment and negative symptoms of the disease which lead to decreased social functioning in the environments of those diagnosed with

the disorder. Whilst this may be true, I feel that the situation is a lot more complex. I agree that low social functioning could impact on the disease, but it is possible that the disorder itself triggers a lack of social functioning. Emotional blunting, often known as flat effect, is a strong contributing factor to social dysfunction. For example, when a person feels neutral on a subject that should elicit emotion, people think the individual suffering from the disorder is strange (Weinberger & Harrison, 2011, npn)

. Bellack & Mueser & Gingerich & Agresta suggest that it is difficult to follow someone experiencing a schizophrenic train of thought in a conversation (Bellack et al., 2004, p.3). Those who suffer from the disorder are known to say things that are odd or unrelated to the topic of conversation. Facial features can be uncommonly inexpressive and the sufferer may avoid eye contact with the person with whom they are in a conversation. Many people have commented that they are not being listened to and have said that they feel more than uncomfortable when conversing with those diagnosed with schizophrenia.

Bellack et al. state: 'Social skills are interpersonal behaviours that are normative and/or socially sanctioned' (Bellack et al., 2004, p.3). They assert that this includes codes of dress and behaviour, rules about what is considered appropriate verbally, emotional expression or lack of emotional expression, social reinforcement and interpersonal distance. This can all be adversely affected when suffering from schizophrenia, so it is little wonder from the normative approach that people with the brain disorder find themselves socially isolated. Bellack et al. say that, whether people with schizophrenia have never developed social skills, or have lost them, they find it hard to fulfill social roles,

establish social relationships or have their needs adequately met. I know that I have found this to be true. I find it hard to fulfill social roles in the workplace and have had great difficulty establishing a long term partnership with anyone. This is evident in my memoir.

Bellack et al. believe that social skills are specific to a situation and that there is no universal definition for these skills (Bellack et al., 2004, p.3). They state that both cultural and situational circumstance dictate societal norms. An example of this is that kissing between family members and lovers is considered normal but not with casual acquaintances nor in formal settings. Direct expressions of anger are considered more normal in the family situation than toward an employer, for example, where a certain degree of unfamiliarity is present. A socially skilled person must analyse the situation and know how to act appropriately, given the circumstances. Bellack et al. suggest that '[t]he unskilled individual is apt to fail in most or all of these spheres and, consequently, experience anxiety, frustration and isolation, all of which are especially problematic for people with schizophrenia' (Bellack et al., 2004, p.4). As a sufferer, I have experienced all of these feelings and still often fail in situations but fortunately succeed in others.

Tsang & Cheung, in Pletson assert that '[p]eople with schizophrenia [have] problems in one or more major areas functioning, such as self care, work or interpersonal relations. It is well documented that people with schizophrenia have significant deficits in social skills and social performance' (Tsang & Cheung, 2005, p. 182). These deficits make it difficult to keep social relationships going and fulfil social roles expected by society in general. It is particularly difficult for

those suffering from schizophrenia to have rewarding relationships with family and friends. Tsang & Cheung suggest that lack of employment opportunity is particularly rife in those who suffer from schizophrenia, due to a social skills deficit and this can have an effect on their lives in the area of marriage, too. This lack of social skills and competencies can also have an effect on a person suffering with schizophrenia whilst looking for work or trying to keep a job.

Tsang & Cheung postulate that people with schizophrenia have great difficulty connecting with people in the workplace and this leads to poor work performance (Tsang & Cheung, 2005, p.5). Many schizophrenics who have employed cognitive behavioural therapy, have managed at least to simulate this connection, even though they do not experience it implicitly. As mentioned earlier by Shayegan, this is what we mean by living a lie to satisfy society. Society is not equipped to take on the differences that schizophrenia presents in the social world. Whether this is the fault of society or due to a lack of understanding is debatable, but stigmatisation exists and makes it difficult for sufferers to gain employment, when they are honest about their condition. Perceptions need to change, not only within society in general, but also within the mental health sector, where there is a tendency among some personnel to mollycoddle people. More emphasis on the social skills within schizophrenia needs to be applied for schizophrenics to gain meaningful employment. In order to gain the social skills necessary to function within society, schizophrenics need more than supported work programmes. According to Tsang & Cheung, it is premature vocational termination that affects the lives of schizophrenics, making it difficult to pull themselves out of a circle of poverty (Tsang & Cheung, 2005, p.5).

Maddux & Winstead (2012) suggest that '[s]tudies of social-cognitive abilities in schizophrenic patients have consistently shown that patients are impaired in their ability to comprehend and solve social problems, processing of emotions, social perception, and theory of mind' (Maddux & Winstead, 2012, p. 252). They also postulate that there is evidence of disconnection between fear and arousal in the brain, which contributes to social withdrawal and paranoia. I find this interesting. It is hard to enable people to socialise with others, when they lack the skills and would rather be alone, for whatever reason that may be. A well-known diagnostic criterion for schizophrenia is blunted or inappropriate affect. Therefore it is common for the sufferer of schizophrenia to show abnormalities in emotional expression, both verbal and facial. According to Maddux & Winstead, the emotions shown are less positive than normal and tend toward the negative, as well as seeming inconsistent with the social context. For example, this could include laughing hysterically at someone's funeral or lacking appropriate emotions over the death of a loved one, such as a mother (Maddux & Winstead, 2012, p. 252).

Maddux & Winstead theorise that schizophrenic patients are less able to read the facial expressions of another individual. This impairment leads to lack of emotional recognition and lack of emotional expression, as described in the previous paragraph (Maddux & Winstead, 2012, p. 252). Therefore, the outcome is poor social adjustment. It is valid to say that, if social awareness were more present in schizophrenics, they would have a better chance of holding down secure employment, having a loving relationship and the support of friends and family. The emotional disconnection experienced by the individual makes it

difficult for society to accept and to make allowances for the differences. The only sure way to stop social stigmatisation is to inform society about the aspects of the disorder that make it hard to function independently. This is the reason for this essay, which will hopefully shed some light on the disorder by educating the reader.

Marinelli & Dell Orto refer to someone suffering from schizophrenia as an empty shell, only a husk of what they once were (Marinelli & Dell Orto, 1999, p.222). In a lot of ways this is an accurate description of what a person endures when suffering the disorder and, despite antipsychotics treating the positive symptoms of schizophrenia, the husk still remains. Not only are social relationships strained but sufferers often seek their own company and prefer solitude, and this adds to their social isolation. Marinelli & Dell Orto state that it is 'well accepted…[that] this [an] expectation of a diminished capacity for socialization in people with schizophrenia that it is included as a diagnostic criterion for [the disorder]' (Marinelli & Dell Orto, 1999, p.222). They also postulate that 'people with schizophrenia [are] typically described as withdrawn and socially isolated, initiating few social contacts, reporting having no friends or superficial acquaintances' (Marinelli & Dell Orto, 1999, p.222). Sufferers therefore rely heavily on their family, for what social contacts they do have, which can in turn strain the family dynamic. It is said that individual sufferers often find themselves more isolated than not and often care little about their family, even though their family cares about them. It is hard for schizophrenics to show feelings when they are not even sure that they are experiencing them. Secondary depression is often common with the disorder as patients often feel

that they have been robbed of the ability to feel, and this can cause distress or despondency in some individuals.

As Marinelli & Dell Orto suggest, families have particular difficulty adjusting to one of their loved ones suffering schizophrenia and this appears to confirm the 'empty shell' image described earlier (Marinelli & Dell Orto, 1999, p.222). Family members sense that it is not that the person afflicted with schizophrenia cannot feel, but that they are a deeply feeling person behind the fog of the illness. Many schizophrenics feel alienated, and lack the feelings as described by Marinelli & Dell Orto, who suggest that many sufferers have to put on a mask in order to satisfy people's expectations. I would argue that someone with schizophrenia enters a neutrality of emotion and only tends to feel base emotions such as fear, anxiety, frustration and despondency. It can be extremely frustrating to be expected to experience a certain emotion toward a situation and not feel it. As mentioned earlier, this is the reason that Shayegan gives for having to lie. Instead of those with schizophrenia ultimately failing to conform in social situations that are difficult, I believe that society should make allowances for their difficulties and differences. This is why education on the disorder is so important. Suicide amongst those with schizophrenia remains high, because often the secondary depression they feel is overwhelming, or they wish they could once again feel happiness, or that auditory hallucinations drive them to commit acts of self harm.

Marinelli & Dell Orto state that 'family members also feel they are able to understand some of the bizarre behaviours and speech of their loved ones and are aware of the fact that their loved ones are experiencing their own sense of

profound loss of the lives and dreams they had prior to becoming disabled'

(Marinelli & Dell Orto, 1999, p. 224). This statement appears to have some merit

as many people with schizophrenia sense a loss of emotion in particular, as well

as a failure to deal with social situations. If it were not for the debilitating

disease, I am sure that the ranks of the homeless amongst people with

schizophrenia would be considerably lessened. Schizophrenics' inability to

function in day-to-day living needs to be addressed in order for them to

encompass the emotional and social reasoning aspects of life. People suggest that

many of those who are homeless are so through choice. Others may be so

because of drug or alcohol dependency. But what of the great proportion of those

who suffer from mental illnesses, including schizophrenia? Having nearly

experienced homelessness myself, the prospect was most frightening. In

paranoid psychosis schizophrenics may feel that someone is out to harm them

and start do go downhill academically as well as having an inability to deal with

finances. With no money, practically no place to live and an inability to continue

with everyday functioning, a sufferer may become withdrawn and socially

isolated.

Green & Horan state that social cognition of schizophrenia falls into four

basic categories: emotional processing, social perception, attributional bias, and

theory of mind. Emotional processing means that a person is able to use their

emotions adaptively. This is broken down into identifying emotions, facilitating

emotions, understanding emotions and managing emotions. Social perception

refers to an individual's ability to identify social roles, societal rules and social

context (Green & Horan, 2010, p.245). Attributional bias reflects how an

individual infers positive and negative events and theory of mind refers to inferring of intentions, dispositions and external belief systems held by others. Green & Horan suggest that, in all these ways, people who suffer from schizophrenia have an inability to meet basic skills in these areas. Green & Horan state that '[d]isturbances in social cognition may be germane to problems in forming and maintaining interpersonal relationships and addressing interpersonal difficulties in work settings' (Green & Horan, 2010, p. 245). Schizophrenic misconceptions can result in difficulties in interpreting the behaviour of other people, which can result in conflicts or social withdrawal.

Research suggests that there is a link between the negative symptoms of schizophrenia and social functioning. Antipsychotics address the positive symptoms of the disease such as hallucinations and delusions, but have little effect on the negative symptoms that exist, therefore making social functioning difficult, regardless of medication. Green & Horan suggest that there is a marked difference in social isolation and effective treatment of schizophrenia (Green & Horan, 2010, p.246). In later, rather than early onset, however, the individual's progression of social functioning is better. It is not impossible for those suffering from schizophrenia to get effective social skills training through cognitive behavioural therapy and acceptance and commitment therapy. These particular forms of psychology have proven to have a beneficial effect on those suffering from the disease. Mindfulness, which finds its roots in Buddhism, is also employed quite commonly, and is particularly effective when analysing what is happening around people. Green & Horan suggest that many questions remain unanswered, such as the connection between negative symptoms and social

cognition (Green & Horan, 2010, p. 246). Little research has been done in this domain and there is a need for more understanding. Green & Horan also postulate that much research is needed to understand the progression of social cognition. They also recommend research to ascertain whether the problems with socialisation are restricted to schizophrenia alone, as it is suggested that it might be a broader issue. Green & Horan assert that '[n]ew information on the types and nature of social cognitive impairments in schizophrenia has stimulated the development of novel psychosocial and pharmacological treatments' (Green & Horan, 2010, p. 247).

Summary

Over the course of this essay I have examined the implications of schizophrenia from the earliest historical records to the present day. Although it is likely that the Egyptians, Greeks, and Romans encountered people with psychosis, there was a lack of knowledge and medical understanding of such diseases and the ways in which they functioned within people. Modern day interpretations of ancient writings are tedious. Kraepelin introduced the modern diagnostic criterion for dementia praecox and formulated theories on the three types of dementia being early, middle and late dementias, which at the time explained psychosis in a limited function. Bleuler reassessed dementia praecox, coining the phrase schizophrenia for early and middle onsets of dementia. He brought in the first and foremost accepted diagnostic criteria for the disease, grouping paranoid and catatonic psychoses under the banner of schizophrenia, when they were previously thought to be a separate medical complaint. More recent research has added to the diagnostic criteria. Effective chemical treatment

of the disorder came about by accident when chlorpromazine was made in the 1960s. Now many people suffering from the disorder are being effectively treated with newer generation medications, which in turn have added to higher levels of functioning for those who suffer from the disease.

Just as importantly, the cultural aspects of schizophrenia have also been examined, shedding light on the cultural perspectives of the disorder. From my personal experience as a sufferer in Australian society, I have found that there is much stigmatisation still present in a supposedly egalitarian nation. It appears that Iranian society in a Muslim context does not view schizophrenia all that differently and that those who suffer from the disorder have to live a lie in order to survive within their culture. The Japanese view schizophrenia disdainfully and as being more dangerous than their British counterparts. It appears that Jewish and African American sub-cultures are each products of their separate attitudes and values, even when it comes down to the way in which they suffer from schizophrenia. This suggests that, despite the sufferer differing from societal norms, they tend to lean towards modes of behaviour which are considered overt or insular. Irish and Italian Americans form a binary opposition to each other, suggesting that the Irish tend to be more withdrawn and the Italians tend to be more overt. Indian society tends to look after patients with the disorder within the community and there are fewer hospitals equipped to deal with mental health in general. There tends to be a world-wide lack of understanding about schizophrenia and different cultures tend to stigmatise those with it, either by not employing them or by viewing them as dangerous.

The social aspects of schizophrenia have been addressed. The emphasis on flat effect, a symptom of schizophrenia, which is one of the most debilitating factors of the disease, has been covered. Social withdrawal and social isolation, as a result of the disorder, has been investigated. Some light has been shed on the secondary depression that often accompanies schizophrenia. People who suffer from schizophrenia have a marked difficulty in maintaining and establishing new relationships, impacting on the sufferer's ability to work, and their functioning in everyday activities. People who suffer from the disorder find emotional expression particularly difficult. This, in turn, leads to further stagmatisation of schizophrenic patients and implies that they should be the ones bending over backward to fit into society. Schizophrenic people would benefit if society were more educated about this illness. The aim of this essay has been to provide some enlightenment. It will hopefully lead to greater social integration of sufferers. This integration should herald a marked improvement in the living conditions for schizophrenics. With a greater understanding, society can surely move forward in the twenty-first century to improve the quality of life for those afflicted with the brain disorder schizophrenia.

Science in recent years believes that dopamine is a contributing factor to the onset of schizophrenia. This essay comes to the conclusion that the cause of schizophrenia is influenced by both biological and environmental factors, and that nurture vs nature is a heated debate for which we truly have no answers. Interestingly, antipsychotic drugs are futile in dealing with the negative symptoms of the disorder of schizophrenia. Positive symptoms of schizophrenia such as hallucinations, delusions and paranoia are often minimalized when

taking antipsychotics, but more research needs to be done into the negative symptoms of schizophrenia and their minimisation. With further research, it is my hope that the living conditions of schizophrenics worldwide, will be improved.

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