A Clinical Discussion of Schizophrenia from the Perspective of the Schizophrenic

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Abstract

The model of studying schizophrenia on the basis of external behaviour is called into question. The author, a mental health professional with the experience of 18 years of the illness of schizophrenia in the middle of her professional career, has a unique perspective to offer—schizophrenia from the interior. The major symptoms of schizophrenia are discussed as well as useful self-help techniques for the schizophrenic to help him cope successfully with the illness.

Introduction

Schizophrenics have for the most part been studied only from the perspective of their external behaviour. Judgements about how ill they are, how well they are functioning, whether they are socially adjusted or not, what treatment alternatives they need, even adjustments in their psychotropic medications, are based on this model.

All of us know that often our external behaviour does not reflect the real state of our mental health. For example, one often goes to obligatory company get-togethers regardless of ones inner state. One can feel depressed, yet one puts on a good "face" at such functions, smiling warmly and sometimes happily in order to fulfil the expected roles so as not to receive unfavourable feedback that might negatively effect one's future employment. This behaviour is characteristic of the schizophrenic, who is often motivated even more than the normal person to conceal his true feelings, functioning, adjustment, etc.

Schizophrenia is a disease that involves profound psychological suffering. The primary symptoms, heightened agitation, auditory hallucinations, delusions, ideas of reference, paranoia, which occur often continuously with little relief, makes the inner life of a schizophrenic one of terror, horror, "indescribable severe torture",[1] and a "living death".[2] The schizophrenic often lives in a continuous state of shock, similar, perhaps, to that of a woman who faces the sudden death of her spouse after 50 years of a happy marital life. At the funeral, she responds to her fellow mourners, often smiling, comforting others, thanking them for their attendance, etc. In a state of profound "denial" of her own grief, she will reassure others she is doing fine. This well-known phenomenon is a common experience among schizophrenics, so much so that it often becomes a lifestyle for them. Thus, when speaking to a psychiatrist, they will state that the CIA is following them, which, of course, will be greeted with some skepticism by the professional, but when they state they are feeling okay, even fine, that remark will frequently be accepted without question as indicating that the person truly feels fine. Clearly, this is a serious error on the part of mental health professionals; it is but one example of the need to rethink the model which is used to assess the schizophrenic and his illness.

Everyone has heard of the attempt made by six blind persons to assess an elephant: one by feeling his trunk, one the tusk, one the tail, etc. In a similar way, without being able to assess the interior events occurring in the mind of a schizophrenic, one is unable to gain an accurate picture of the overall disease of schizophrenia and what if anything the external behaviour of schizophrenics really means.

Thus far, those who have personal knowledge of the interior of the schizophrenic mind, the schizophrenics themselves, when they have written on the topic of schizophrenia, have been regarded as contributing only anecdotal, personal case histories, which are, by definition, biased and subjective. However, it would seem equally subjective to analyze the disease of schizophrenia from the "outside" without having detailed knowledge of the whole picture. Those who are able only to guess at the meaning and significance of the external behaviour are scarcely able to be objective. It is not surprising that often their guesses have less general overall reliability than

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those of the schizophrenics themselves.

The time has come for a trained mental health professional with the vantage point of both the interior and external manifestations of the disease of schizophrenia to call into question the model of external behaviour that is commonly used to assess schizophrenia. This should be done especially for the benefit of those serious mental health professionals who truly wish to be effective in their treatment of schizophrenic clients.

The Major Symptoms of Schizophrenia

Many "normal" people feel that at times they have had an experience, albeit perhaps fleeting, with one or more of the major symptoms of schizophrenia, i.e., heightened agitation, paranoia, ideas of reference, delusions, or auditory hallucinations. This is untrue. The primary difference between a schizophrenic and a "normal" person's presumed experience of these symptoms is that in schizophrenia the symptoms are spontaneous,[3] whereas in the "normal" person, the symptom involves some related thought,[4] even if very minimal.

A schizophrenic experience of agitation, for example, involves an overwhelming motor impulse to move, sometimes one or more parts of the body, sometimes the entire body. No relevant thinking takes place before this impulse (which is uncontrollable) occurs. In the "normal" person, some fleeting related thought always takes place, which produces the anxiety which then precipitates agitation. Thus, the process in a "normal" person can be interrupted at different stages, whereas, in the schizophrenic, it is completely spontaneous. If there is any thinking occurring in the schizophrenic, it is a nonsensical experience of unrelated, unbidden, unmeaningful, hurtling ideas; not a clear anxiety provoking thought(s) which produces a comprehensible heightening of anxiousness, leading to obviously related agitation.

The occurrence of paranoia in schizophrenia is similar. A schizophrenic practically never initially notices whether someone or something appears suspicious. This type of thinking is added later to explain to "normal" people why the symptom reflects reality. Instead, when a schizophrenic views the environment, any unrelated feature whatsoever may trigger the paranoia. The stimulus could be a person, some interaction going on, a store, a car license plate, anything.

The idea of reference, e.g., thinking someone is playing the song on the radio just for you, is similarly spontaneous. Not only is the thought spontaneous for the schizophrenic, but his emotional investment—intense and high pitched—is spontaneous. The "normal" person typically builds up his emotional investment more gradually. Even in extreme circumstances, during which a "normal" person reacts intensely, and immediately, there is always a delay. In the schizophrenic there is no delay whatsoever.

Many mental health professionals feel that delusions are at least partly the result of the schizophrenic attempting to make some sense out of his symptoms (i.e. paranoia, ideas of reference, delusions, auditory hallucinations, etc.). This is not true. There is a real difference between the schizophrenic's own need to comprehend his symptoms (which is rare for the schizophrenic—he already truly believes in them—he typically needs no further explanation) and a delusion. The experience of delusions is an overwhelming, spontaneous eruption of his inner-most-being, culminating in a previously unrelated, unthought idea of profound proportions, which consumes his conscious functioning. Thus, the delusion itself is often unrelated to other symptoms and is not an explanation of them, but a separate experience. This experience is then incorporated into his other symptoms and only then are explanations offered, usually primarily on behalf of "normal" individuals. This is offered for communications purposes and to make the communication more palatable to the "normal" persons, so as not to be the recipient of negative, unsociable feedback.

The only symptom in schizophrenia with a very real psychological component is auditory hallucinations. They are not the "disembodied" voices they have been thought to be. Upon hearing a voice, the schizophrenic almost immediately attempts to attach the voice to a real person or entity. This process, although not spontaneous (which is why there is a psychological component to it), is an automatic one. The interpretation of a voice is not always a physical one, but can be a metaphysical one. For example, some voices are thought of as coming from individuals that are living and some are thought of a coming from some spiritual source—e.g., they are "old souls" no longer living, but

existing in some other domain. This commonly occurs even with the non-religious schizophrenic, some voices are identified as individuals the schizophrenic is personally attached to, some as professional functionaries (i.e., telephone operators, for example). The auditory hallucinations are not psychologically interpretable, however, even though there is a psychological component to the schizophrenic's response to them. This is because the auditory hallucination itself is as spontaneous as the other symptoms of schizophrenia. However, the symptom and the automatic attempt to interpret it, as a package, is not responded to in the same way as other symptoms. The schizophrenic responds to the auditory hallucination and its interpretation as a unit, whereas with paranoia, ideas of reference, and delusions, the symptom itself is responded to. No "normal" person believes or relates to or takes action on the basis of a voice coming out of nowhere. Neither does a schizophrenic. This voice is first identified and then the response is made. In the case of another symptom of schizophrenia, delusions, the symptom itself is responded to. If the delusion is that the CIA is following you, the response—since the material has been identified as coming from the CIA—is appropriately made on that basis.

One often observes schizophrenics talking out loud to their hallucinations. The need to talk back to this profoundly invasive symptom is compulsive. The schizophrenic can ignore auditory hallucinations for a short time, but eventually he has to respond. The experience is one of absolute necessity to reclaim ownership of his interior, to establish personal authority over the hallucinations.

Some schizophrenics can "talk back" to their voices in their thoughts only, but there is much more psychological relief experienced by the schizophrenic if he talks back out loud. The talking back is experienced as action taken over an invasion of the interior, thus a discharge of tension.

The above five symptoms: heightened agitation, paranoia, ideas of reference, delusions, and auditory hallucinations are perhaps the most central and well-known symptoms of the disease of schizophrenia. One which is not well-known, but also quite common is what I have coined the "look alike" symptom. In this there is a loss of ability to discriminate and an over-generalization of stimuli regarding the physical appearance of other people. Thus, an individual who bears some resemblance to a person in the schizophrenic's environment becomes that person himself. This also is a spontaneous symptom and the emotional investment is real. This symptom is often confused with a delusion. For example, "I saw Kenny Rogers on the street today" is actually a "look alike" phenomenon and not a real delusion.

I would like to mention two other symptoms of schizophrenia briefly: scanning and hypervigilance. These two symptoms heightened the intensity of other major symptoms because of a sensory overload. Because of scanning and hypervigilance, there are many things included in the schizophrenic's conscious environment which go largely unnoticed by the "normal" individual. These symptoms widen the field of possible sources for paranoia, ideas of reference, delusions, look-alike, etc. The symptoms of scanning and hypervigilance appear to be paired with each other and with the symptom of paranoia. The three occur simultaneously. They are not as paired with ideas of reference, delusions, or auditory hallucinations. When the "normal" person senses danger, he too has a heightened sense of awareness, as does the paranoid schizophrenic. The "normal" person, with heightened awareness is not just more alert. He also, although in a more circumscribed manner, becomes more vigilant and scans.

Self-Help Techniques for the Schizophrenic

Some methods for helping to alleviate the symptoms of schizophrenia are well-known. For example, a highly structured lifestyle is desirable because it reduces sensory input, that is, it helps prevent the person from becoming over-stimulated, thus reducing symptoms somewhat. Living with another person, particularly one who is not as equally burdened with a severe illness, helps the schizophrenic focus more on his external environment, rather than on his internal malfunctioning, i.e. his symptoms. However, there are many less well known forms of "physical therapy" that should be engaged in by the schizophrenic to help alleviate his symptoms.

Just as the "normal" person, the typical schizophrenic has already discovered methods

to improve his health but which at first glance appear to be yet another by-product of his illness. For example, many schizophrenics who live on the streets, and whose behaviour is thus observable, are constantly walking. It appears that the effect of walking significant distances (3 to 6 miles a day at least) is like that of the exercises prescribed for brain-damaged individuals, one of patterning the brain. Obviously, the schizophrenic has the usual side-effects of exercise, also, that any "normal" person enjoys: a sense of well-being, and relaxation. But in addition to this, he can experience a reduction in the symptoms of schizophrenia themselves and have more normal thought patterns. The experience itself is as though one were travelling down a dirt road under repair with large ruts in it, wobbling back and forth, then gradually moving over to a smoothed out section of the road with a firmer more secure and "righted" ride.

Another method of physical therapy which street schizophrenics engage in is the consumption of alcohol. Many schizophrenics appear to prefer alcohol to their medication. Alcohol even in excess is preferred by these schizophrenics, who may or may not be alcoholics. Alcohol has been used for medicinal purposes in the past.

In contrast to alcohol, the phenothiazine are disliked by schizophrenics not simply because of their sedative effect (thus schizophrenics on this medication have the urge to smoke cigarettes, and consume large amounts of caffeine, etc.) or because of other side effects such as, extrapyramidal disorder or tardive dyskinesia. They are primarily disliked because they make the schizophrenic unable to really connect with his own personality. This is not the same as the symptom of depersonalization. This is not confusion about or absence from one's self-identity; instead this is a distancing from one's self-identity. In addition to the real discomfort of this condition of distancing from one's self-identity, the schizophrenic is prevented by it being able to utilize fully the coping skills he very much needs in order to deal with his disease effectively. The loss of initiative, noted by Dr. Abram Hoffer, is one of the effects of this distancing. Perhaps this side-effect is a major reason why the phenothiazines are not abused by drug addicts.

Alcohol does not have to distancing side-effect. Drinking while experiencing schizophrenic symptoms has a generalized quieting effect on all the symptoms. The problem, however, comes when the schizophrenic has to withdraw from the alcohol. At that time, the symptoms become worsened; they are actually somewhat worse than before one began drinking the alcohol. This is why some street schizophrenics who may not be alcoholics appear nevertheless to try to stay intoxicated. Perhaps a small and judiciously used amount of alcohol could be used effectively to help control the symptoms of schizophrenics in some cases.

The general theory underlying many of the following self-help techniques for schizophrenics is that due to the significant interior deprivation of the schizophrenic resulting from his symptoms, he is excessively dependant on the external environment for gratification. The "normal" individual can always retreat to his interior for gratification (for example with self-reinforcing statements such as "I did a fine job.", positive imagery, such as hiking in the mountains or lying on a beach; relaxation imagery, prayer, etc.). The schizophrenic is often so overwhelmed by devastating paranoia, delusions, ideas of reference, auditory hallucinations, etc., and the interior "racket" is often so chaotic and loud that he is unable to enjoy the benefits of such self-reinforcing techniques. Thus, the external environment is crucial for the schizophrenic. As much as possible, it should be arranged so as to compete successfully with his internal preoccupation. The schizophrenic needs to be genuinely and naturally interested in his external environment. He needs to make these choices individually, as does the "normal" person; otherwise he will decompensate somewhat despite himself. No amount of will-power can encourage a schizophrenic to attend to his external environment under the influence of the disease of schizophrenia, unless the interest is truly there. The internal preoccupation is experienced as a compulsion and competition with this compulsion has to be yet more powerfully inducing.

Most employment offered to the schizophrenic is highly unrewarding—menial jobs like janitorial work or waitressing. These jobs are dull and offer little external stimulation or gratification to the average schizophrenic—

something needed urgently by the schizophrenic to distract himself from his interior horrors and to motivate him to concentrate instead on his external environment. Thus, the schizophrenic should be offered his most rewarding, challenging, and stimulating job preference by employers who wish to contribute to his health. This will enhance his capacity to cope with his illness and reduce the effects of his symptoms.

In addition the schizophrenic should have enough money to purchase rewarding external material goods and services, including entertainment, over and above the basics: food, shelter, and clothing. If he is unable to manage his money, he should be assisted in managing it. but the money should be made available to him. This is sometimes the only quality in life available to the schizophrenic. I would like to mention here the considerable importance to the schizophrenic of owning an automobile, the schizophrenic's "wheelchair". Schizophrenics, who are fortunate enough to own a car, often take drives to help reduce symptoms when they appear to be decompensating. Even quite psychotic schizophrenics can drive if they have had recent driving experience and are not heavily drugged. While driving, the necessity to focus on one's external environment is very real, life and death can actually be involved. Thus, symptoms sometimes can be brought into more control, when driving, particularly to a specific, rewarding destination (structure, gratification). Also, just as "normal" individuals use a car to reduce the "hassle" and increase convenience, so the schizophrenic with the little psychological reserve available to him after struggling with his disease, in many ways, needs this convenience more than the "normal" individual. When one is a schizophrenic, long boring waits for buses and the tediousness of travel with few external demands on the brain, have been known to precipitate decompensation.

For the schizophrenic, there is a very real premium to getting the daily chores of life done actively, quickly, efficiently, in a gratifying, unfrustrating manner, so that the focus can remain on the external environment.

A schizophrenic should try to avoid waiting in lines. Auditory hallucinations, for example, can become so overwhelming with passive behaviour such as this, that decompensation is again possible.

Of course, as with the "normal" person, one of the most rewarding things in life is to be with another person of the opposite sex that you are in love with. Unfortunately, this experience is not often available to the schizophrenic, particularly due to his external behaviour which, instead of being understood, as are the side-effects of diabetes, is rejected by many potential mates. The schizophrenic is perfectly capable of loving. (He has sometimes been questioned about his choice of the object of his love, but not for the inability to love itself.) For him, there is no tonic like a love relationship; it helps him cope with his disease immeasurably better. Love is perhaps the only interior thing a schizophrenic is able to fully appreciate.

There was a recent article in a Bay Area newspaper about the use of radio earphones to block out the auditory hallucinations of the schizophrenic. Although this can help some schizophrenics in the short-run, after an hour or so the music, talk shows, etc., become too boring for it to be a complete distractor. It is more effective to hear live music or live shows because of the increased stimulation from other sources such as the dress, movements, mannerisms of the musicians, actors, etc., themselves, other individuals' behaviour in the entertainment hall, bar or cabaret and the general party-like atmosphere. Some schizophrenics have found rock and roll music particularly helpful (even though another form of music may be preferred aesthetically by that schizophrenic). The loud decibel level of this form of music combined with the distinctiveness and insistence of the beat, helps both to distract and pattern the brain rather effectively.

Finally, I would like to mention one self-help technique that is most useful to the schizo-phrenic—learning to monitor his dyspercep-tions. If a "normal" person perceives the form of a human being in a darkened shadow in a room, he doesn't immediately assume there is another human being actually present in the room. From his experience, he knows that shadows can be deceptive. Thus, he decides to walk over to the shadow to investigate the form. In a similar manner, the schizophrenic can learn through experience to distrust his dysperceptions. For example, if a schizophrenic thinks songs are being played specifically for him on the radio, he should

be encouraged to call the radio station and find out. "Normal" people need to become more encouraging of this type of behaviour instead of ridiculing it. After all, this is "normal" behaviour for someone with dysperceptions. Using this method, some schizophrenics, over the years, learn to distrust their perceptions and monitoring them often becomes more frequent and self-reinforcing. Severely ill schizophrenics usually cannot be dissuaded even with this technique initially. But it does not mean it should be discouraged. It is not always the preferred technique simply to ignore the symptoms of schizophrenia. There is a real difference between actively participating in his dysperceptions, which serves only to frighten him more, and encouraging him to monitor his dysperceptions.

It should be emphasized that these self-help techniques do not have any curative effect on the disease of schizophrenia. However, they are somewhat helpful in preventing relapses and they make the life of a schizophrenic significantly more tolerable by providing some relief from the symptoms of the disease. If the strain of experiencing the disease, which is enormous, is reduced, it is quite possible that in the long run the schizophrenic would experience less of his illness.

References

1. Reprint, "A Schizophrenic Illness described as Indescribable Severe Torture", the Huxley Institute for Biosocial Research Inc., Boca Raton, Florida.
2. Pfeiffer, Carl, Mental and Elemental Nutrients, Keats Publishing Co., Connecticut, 1975, p. 402.
3. The word "spontaneous" is used here rather than "automatic" because from the perspective of the schizophrenic, mental control of the symptom can override the symptom, whereas in "automatic" (see auditory hallucinations), the mental control itself is overridded.
4. Sometimes "normal" people don't literally feel they have experienced thinking, but the process for them involves a mental process not a spontaneous dysperception.