DECONSTRUCTION AND RECONSTRUCTION OF

SCHIZOPHRENIA

by

HARRISON HERTIG

A THESIS

Presented to the Department of Psychology
and the Robert D. Clark Honors College
in partial fulfillment of the requirements for the degree of
Bachelor of Science

June 2015

An Abstract of the Thesis of

Harrison Hertig for the degree of Bachelor of Science
in the Department of Psychology to be taken June 2015

Title: Deconstruction and Reconstruction of Schizophrenia

Approved: _____

Professor Mark Alfano Department of Philosophy (and Institute for Cognitive and
Behavioral Sciences)

Through literary review and my own experiences working with the *International
Society of Psychological and Social Approaches to Psychosis*, this paper will explore
the utility and consequences of the construct 'schizophrenia' in order to reconstruct
more empowering approaches towards psychosis. By using the framework of Thomas
Kuhn's theory of scientific revolutions this paper is divided into three main sections:
first, investigating the historical make-up of the psychiatric paradigm and
schizophrenia, then reviewing psychological and philosophical critiques regarding
schizophrenia, and finally proposing progressive methods of treatment which serve to
empower, rather than damage, those suffering from psychosis.

Acknowledgements

I would like to thank ProfessorsMark Alfano, Jordan Pennefather, and Barbara Mossbergfor helping me to fully examine the specific topic and consider the various perspectives and contexts related to this subject matter. Also, I would like to thank Ron Unger for introducing me to ISPS which provided important contributions to the development of this paper. Further, I would like to thank my family for providing me with this opportunity through their tremendous support.
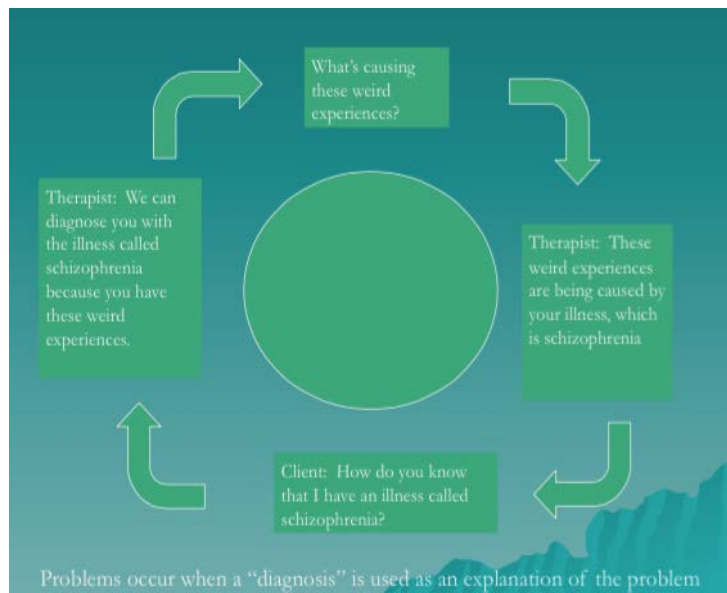
Table of Contents

List of Figures

Figure 1:

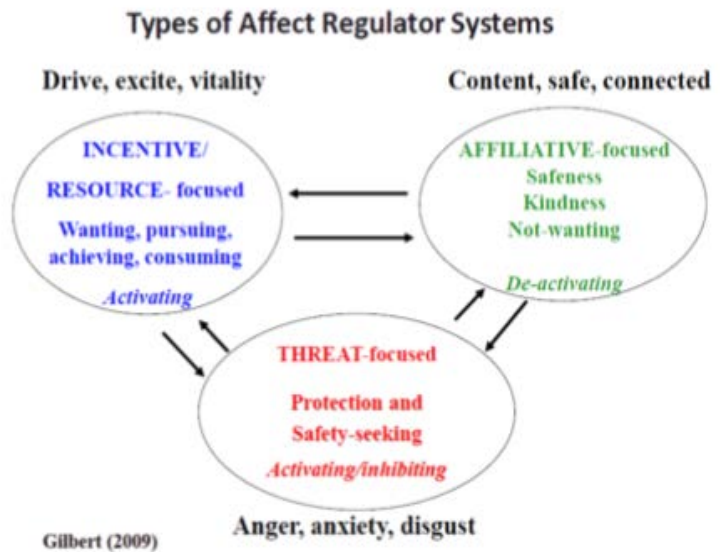From Ron Unger, displays the circular logic of typical therapy diagnosis.

Figure 2:

From Gilbert (2009), displays the 3 system model of affect regulation

Introduction / Chapter 1: The Psychiatric Paradigm and Making-up of Schizophrenia

Scholars and mental health professionals spend a considerable amount of time and resources investigating the construction of schizophrenia. This investigation has led to intense debates about the nature of the hypothesized disease. Although the construct of schizophrenia has been around for over 100 years, much remains a mystery about the causes and course of the disorder. Some researchers point towards biological factors, while others analyze possible social factors. While the debate rages amongst professionals, those suffering from psychotic episodes are forced to take a subsidiary role and wait for conclusions. Despite the general scientific assumption that phenomena should be studied objectively, when the subject of study is human beings it becomes challenging to remain fully objective because subjectivity is critical and intrinsic to the human psyche. The voices and experiences of those suffering should not take a back seat to expert analysis, but should rather be at the forefront of investigation contributing to the collaborative quest for an understanding of suffering. For too long, voices of suffering have been silenced. This is especially the case regarding schizophrenia, as hearing voices is considered a symptom that should be eradicated. Restricting the voice of the subject of study damages the progress of treatment, marginalizes those suffering, and consequently perpetuates suffering. In order for treatments of schizophrenia to qualitatively progress, research and implementation must not only be executed by professionals, but structures must allow voices of suffering to take on a more prominent and meaningful role. Thus, the main assumption of this thesis is that the primary role of the medical system is to support and empower those who suffer.

My investigation will focus on schizophrenia as a case-study for broader understanding of suffering. Schizophrenic suffering does not serve as an ultimate model for suffering in general, but examining schizophrenia illuminates the expansive and personal impacts of suffering. It is also important to explore schizophrenic suffering because of its highly enigmatic characteristics that are attached to social stigma. If the general population has trouble empathizing and accepts common misconceptions about schizophrenia, this helps foster a regressive environment. Many domains influence schizophrenia, and I do not have the expertise or experience to analyze all of them. However, this analysis will incorporate research into psychological and philosophical conceptions related to schizophrenia. I will also incorporate my own experiences of consulting professional therapists, and attending meetings with the *International Society for Psychological and Social Approaches to Psychosis*. While I will not be able to integrate all domains related to schizophrenic suffering, my approach will explore key factors influencing the course of schizophrenia, as well as explore efficient methods for recovery and prevention. Currently, the medical domain dominates the conversation about views and treatments of schizophrenia. Although the medical domain necessitates a role in future progress, the theories, discourse, practices, and institutions used by the medical domain must be reevaluated.

Currently, treatment of schizophrenia is primarily influenced by the psychiatric paradigm. Thomas Kuhn (1962) defines a scientific paradigm as the "law, theory, application, and instrumentation together— [that] provide models from which spring particular coherent traditions of scientific research" (p.10). Paradigms refer to the set of foundations and assumptions that guide the progress of research. According to Kuhn,

scholars work diligently to solve the problems put forth by a paradigm. Scientific discoveries that do not comply with the relative paradigm are often swept under the rug. However, if enough contrary discoveries accumulate, then the scientific community can be said to be in a state of crisis. This state of crisis is accompanied by heavy resistance from supporters of the challenged paradigm. In order for a crisis period to evolve into a complete paradigm shift, a new theory must appear that is incommensurable with the previous theory. Eventually, the new theory must gain more support than the old theory.

Although Kuhn's theory of scientific progress is not perfect, it serves as an excellent model to describe the progression of the current psychiatric paradigm. The psychiatric paradigm has served as the foundation for schizophrenic treatment for over half a century. This paradigm asserts that schizophrenia is a *real* disease, independent from normal human deviance. Despite progress made within the psychiatric paradigm, many professionals have critiqued the paradigm for contributing to misconceptions about schizophrenia, influencing over diagnosis, and ultimately perpetuating suffering. Dissenters claim that in order for a scientific phenomenon to be considered *real*, it must obtain scientific validity and reliability. Validity refers to the independent existence of a phenomenon, while reliability refers to the ability to consistently account for the same phenomenon through multiple trials. Many dissenters argue that research overwhelmingly supports the idea that schizophrenia is neither a valid or reliable construct. Ultimately, dissenters have challenged the psychiatric paradigm for many years in what could been regarded as a Kuhnian crisis period.

It is a common misunderstanding to assume that when one asserts schizophrenia is not a *real*disease, that one believes people are fabricating their suffering. This could

not be further from the truth. Schizophrenic skeptics believe and acknowledge that suffering is all too real. The distinction between skeptics and believers lies in what they believe to be the source of suffering. For believers, the source of suffering is due to schizophrenia. However, skeptics argue that the labeling of schizophrenia is still premature, and that the source of suffering is often due to a multitude of factors. Skeptics see the label itself, as a potential layer of suffering. The consequences of labeling humans has been studied extensively by Ian Hacking (1999), who argues "that numerous kinds of human beings and human acts come into being hand in hand with our invention of the categories labeling them" (p.170). Hacking refers to this process as *making-up-people*. Again, this does not infer that people fabricate or *make-up* their suffering, but argues that categories and labels intricately influence people's subconscious, beliefs and actions. Hacking investigates the process of *making-up* multiple personality disorder, but recognizes there can be no general theory of making up people as "each category has its own history" (p.168). Therefore, it is important to explore the *making-up* of schizophrenia in order to recognize its consequences and create solutions.

Most importantly, the medical field must realize that a history of over diagnosis and misdiagnosis creates ramifications, that harm the individual's ability to recover. This thesis explores the 'making up' of schizophrenia and then asks two essential questions. First, why is the current psychiatric paradigm in a state of Kuhnian crisis that must be resolved? Next, how can the 'making up' of schizophrenia be used to empower, rather than damage, those who suffer? By investigating schizophrenia and the progression of treatments, we see that the schizophrenic label has primarily served a

4

pragmatic function to help psychiatrists efficiently converse about multiple patients. Despite its pragmatic value, the current state of America's mental health system reinforces assumptions that are damaging to suffering individuals. This is important because if receiving a diagnosis damages an individual's self-esteem and well-being, then the diagnostic system perpetuates suffering. Currently, the medical field diagnoses brain diseases primarily based on behavioral symptoms, which ironically ignores studying the complex biological properties of the brain and the convoluted structure of our society. In order for research and treatment methods to progress, psychiatrists must quit hastily diagnosing behaviors, focus on enhancing techniques to find the true source of suffering, and create a safe environment that empowers the suffering.

Roots of the Modern Psychiatric Paradigm and Schizophrenia

Schizophrenia, the word alone is likely to generate strong emotions with anyone impacted by this form of suffering. Whether one is personally impacted or knows someone suffering, schizophrenia can become a life altering experience for all involved. Yet, there is still much confusion about the nature of this *disease*. For the American general public, schizophrenia is often associated with words such as crazy, psychotic, or chemical imbalance. However, these associations only scratch the surface of the reality of schizophrenia. This section will aim to explore the progression of the psychiatric paradigm and the *making-up* of schizophrenia.

The roots of this paradigm can be traced as far back to Ancient Greece or China, as the conception of mental illness has been around for at least the past 2,000 years. For the sake of focus, I can not trace its entire history. However, the biggest influence to the framework used by experts today comes from ideas propagated by European and

American societies during the 18th and 19th centuries. For a great portion of history, physical or mental illness was considered a result of spirit possession or other abstract causes. During the course of the American and European Scientific Revolution, experts disregarded old religious beliefs in favor of physiological and psychological causes. However, this shift from external religious authority to reductionist medical authority, catalyzed drastic consequences for the medical industry and the mentally ill. In Whitaker's novel *Mad in America* (2002) he explores the progression of the treatment of madness in America. He mentions the 1774 passage of legislation in Britain which granted physicians "the sole arbiters of insanity" (p.9). Physicians acquired the sole authority in determining whether or not someone required life confinement in an asylum. This coincided with a significant growth in the medical industry that allowed physicians to make a fortune running asylums, which essentially became businesses. For example, Whitaker (2002) mentions that asylums "served as convenient dumping grounds for relatives who were simply annoying or unwanted…a physician who would attest to this fact could earn a nice sum" (p.8-9). This elevation of the status of the physician was unparalleled in Western society, and significantly altered the relationship between physician and patient.

Whitaker (2002) describes how Thomas Willis's influential 1684 text on insanity concluded "that the insane were animal-like in kind", which reflected the prevailing conceptions "that reason was the faculty that elevated humankind above the animals" (p.6). To say that the mentally-ill were treated harshly would be an understatement. Their independence was stripped, as physicians gained authority in determining what was best for patients. Common treatment methods included being

forcefully strapped to a chair, bleeding, induced vomiting, starvation, and drowning. This process exemplifies the creation of an *out-group*, a group with which individuals do not identify. In Aronson et al. (2010), the authors describe the phenomenon of *out-group homogeneity,* which is the perception that "those in the out-group [are] more similar to each other than they really are, as well as more homogeneous than the in-group members are" (398). Ramifications of creating out-groups have also been studied extensively by scholars including Michel Foucault. In his investigation of madness, *Madness and Civilization*, Foucault (1965) uses the term "great confinement" to argue that the detainment of the mad served a political function of suppressing threats to social order (p.38). In this sense, hospitals were closer to prisons than services to support suffering. This influenced a disconnect between the physician and patient, where the physician took on an authoritative role and the patient a subordinate role. Although these attitudes have decreased in intensity, the remnants remain. This excerpt by Foucault emphasizes how delegating reason to explain madness consequently silences the mad.

> "In the serene world of mental illness, modern man no longer communicates with the madman: on one hand, the man of reason delegates the physician to madness, thereby authorizing a relation only through the abstract universality of disease; on the other, the man of madness communicates with society only by the intermediary of an equally abstract reason which is order, physical and moral constraint, the anonymous pressure of the group, the requirements of conformity. As for a common language, there is no such thing; or rather, there is no such thing any longer; the constitution of madness as a mental illness, at the end of the eighteenth century, affords the evidence of a broken dialogue, posits the separation as already effected, and thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of such a silence" (x-xi)

These negative attitudes toward the mentally ill would set the stage for Emil Kraepelin and Eugen Bleuler, two of the biggest influences in the creation of schizophrenia. Kraepelin in specific contributed many ideas that influence the modern diagnostic paradigm. Progress in medicine during this time period was impressive, but psychiatrists hastily attempted to discover new psychological diseases. Classifying a new disease was lucrative, as Read et al. (2004) describes how Kraepelin received over $500,000 from the Rockefeller Foundation (p.21). Mostly relying on observations of behavioral symptoms, Kraepelin eventually claimed to discover *dementia praecox* around 1896. Despite the absence of any biological evidence, Kraepelin assumed *dementia praecox* was an independent disease entity with degenerative outcomes for the individual. Read et al. mentions that Kraeplin believed "people who got better didn't have dementia praecox" (p.22). This assumption was challenged by Eugen Bleuler who noticed that many individuals were successfully able to recover from the hypothesized disease. This disagreement led Bleuler to coin the term *schizophrenia* in 1908. Although it was important for Bleuler to recognize that the disease was not always degenerative, Bentall (1990) argues that he, like Kraepelin, "overlooked the necessity of demonstrating that his construct was derived from an observed pattern" (p.13). The methods used to determine an illness, by both Kraepelin and Bleuler, have been highly criticized for being both scientifically unreliable and invalid. For example, Bentall notes that the descriptions of dementia praecox and schizophrenia are virtually identical to "the infectious disorder called encephalitis lethargic and its Parkinsoniansequelae" (p.15). It is not argued that Kraepelin or Bleuler made-up their discoveries, but that they prematurely labeled a disease that they had little evidence to support. Further, they also

ignored the role of social context, as Read et al. argues that "some people get upset when locked up" (29). Instead of acknowledging these experiences as normal reactions to captivity, psychiatrists often pathologized these symptoms as proof of an abnormality. Despite retrospective critiques of the birth of schizophrenia and the diagnostic paradigm, these views faced little resistance at the time and carried over into what would become one of the most atrocious periods in the history of mental illness.

This atrocious period was primarily influenced by the eugenics movement initiated by Francis Galton. Although Darwin's theory of evolution did not specifically call for a eugenics movement, eugenics latched onto Darwin's idea that species evolution was determined by the quality of genes. Whitaker explains that Galton coined the term eugenics in 1883 "to encourage [the] fit to procreate and prevent [the] unfit from doing the same" (p.44). This notion that humans could breed a superior race if they restricted the breeding of unfit humans, led to severe consequences for asylum patients of the time. Although the eugenics movement started in Europe, America would eventually become heavily involved. Whitaker argues that it was in America where "a society would first develop laws for compulsory sterilization of the mentally ill" (p.45). This was marketed as a benefit to society and to the mentally ill, as sterilization was said to eliminate tainted genes from the gene pool. By inferring insanity and undesirable behavior to be heritable, psychiatrists were able to justify the sterilization and murder of thousands of patients. Besides sterilization, other inhumane methods of treatment during 1900-1950 focused on reducing the brain function of the insane. This was thought to help the insane become more simple minded. Common treatments included electroshock therapy, inducing comas, and prefrontal lobotomies.

The mentally ill were not voluntarily signing up for these treatments, but were being forced to endure them. While contemporary society has moved away from eugenic principles, it is still commonly accepted that the mentally ill have defective genes.

Psychiatric Revolution of 1950's

Two of the most prominent contributions to the modern psychiatric paradigm would evolve during the 1950's. The ideas of Kraepelin and Bleuler would provide the framework, in which these developments arose. The first of these developments was the original *Diagnostic and Statistics Manual of Mental Disorders*(DSM) published in 1952, while the second was the introduction of anti-psychotic drugs in 1954. Both of these developments contributed to the eventual deinstitutionalization of the mentally ill, and both play a significant function in the current treatment of schizophrenic suffering.

When the first DSM was introduced in 1952, it came at a time when asylums were over capacity, and many returning *WWII* veterans experienced suffering from war trauma. The American Psychiatric Association decided to create a classification system, which supposedly served to efficiently study and treat mental illness. Reflecting the assumptions of Kraepelin, the DSM affirms that mental disorders are *real* disorders, which are located in the brain, and are described by behavioral symptoms. However, the DSM classification of homosexuality as a disorder exemplifies how diseases of the time better reflect social attitudes, rather than natural disorders. In any case, the DSM primarily served a pragmatic function by allowing experts to efficiently group together patients with similar symptoms. It has since become the fundamental guide for all of clinical psychology.

The next most significant development to modern schizophrenic treatment came in 1954 with the introduction of chlorpromazine. Whitaker argues that at first America perceived lobotomy as "the fruit of both good science and a humanitarian empathy for the mentally ill" (p.138). However after the atrocities of *WWII*, Americans started to question the moral valence of treatments such as lobotomy, electroshock, and sterilization. American psychiatrists needed to find a new treatment process that did not reflect the brutality of Nazi's. Chlorpromazine was the first anti-psychotic medication to be developed. Although it was first synthesized in Europe, Whitaker explores how global leadership in drug development shifted to the United States because the financial opportunities were much greater (p.148). There was a growing relationship between pharmaceutical companies and physicians. By using mass marketing, chlorpromazine eventually became the successor to schizophrenic treatments and was hailed as a wonder drug.

The growth of the pharmaceutical industry coincided with a social movement away from asylums. American asylums had been economically unstable for quite some time. Whitaker describes how in 1963 President Kennedy unveiled his plan for reforming the nation's care for the mentally ill. Kennedy stated that "the new drugs made it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society" (p.156). Although community support for the mentally ill was a positive step forward, this movement prematurely trusted the value of anti-psychotic drugs. Unfortunately, the foundation for deinstitutionalization was based on the assumption that anti-psychotic drugs benefited the suffering. Whitaker argues that deinstitutionalization "was a good-news tale that

was missing one key voice: that of the mentally ill" (p.158). When physicians sold the idea to the general public that anti-psychotic drugs were beneficial, they did so knowing that the drugs had profound side-effects. One side-effect of chlorpromazine was the induction of Tardive Dyskinesia. This side-effect produced involuntary facial and body twitches. Other side-effects contributed to death of brain tissue, and to a lack of motivation. Despite these alarming consequences, physicians succeeded in convincing the nation that anti-psychotic drugs were the most effective and humane approach for treating schizophrenia.

Aftershock of the 1950's and Modern Making-up of Schizophrenia

The modern *making-up* of schizophrenia is heavily influenced by the psychiatric paradigm, the DSM, and anti-psychotic drugs. Bentall (1990) estimates that "approximately 1% of individuals in western countries can be expected to be labeled 'schizophrenic' at sometime in their lives" (p.23). Schizophrenia is related to states of psychosis, which are mental states that involve a loss of contact with reality. The *DSM-IV* defines psychotic as "the presence of certain symptoms" (p.297). Although symptoms vary across cultures, it is assumed that schizophrenia is a universal disease that is mediated through culture. Subtypes of schizophrenia were included in the *DSM-IV*: paranoid type, disorganized type, catatonic type, undifferentiated type, and residual type. These subtypes have since been thrown away due to a lack of reliability. However, the variability amongst people diagnosed with schizophrenia is immense. Due to media coverage, schizophrenia is often associated with psychopaths and murderers. This does not reflect reality because many people experience states of psychosis and do not act evilly.

The American Psychiatric Association recently published the fifth edition of the *DSM* (2013). For someone to attain insurance and treatment for mental illness in America, the person must be diagnosed with an illness from the DSM. Schizophrenia is one of hundreds of hypothesized disorders. The DSM primarily describes behavioral symptoms, but spends little time explaining causes or methods of treatment. Further, it is assumed that symptoms are harmful products of the disorder, which should therefore be eradicated. According to the DSM, there are five key symptoms of schizophrenia: 1) delusions, 2) hallucinations, 3) disorganized speech, 4) disorganized or catatonic behavior, and 5) negative symptoms. Delusions are described as erroneous beliefs, such as thinking the CIA is following you. Hallucinations can occur through any sensory modality, but the most common form of hallucinations are auditory. Negative symptoms are described as a lack of emotion, sociability, or motivation. The DSM claims that a person must have two of these five symptoms, but at least one of those symptoms must be from the first three criteria. Further, it requires that disturbances have persisted for at least six months. Despite these seemingly arbitrary cutoffs, the DSM does not lack in detail.

Since the publication of the original DSM, the number of disorders has increased from 106 to near 300. Has the increase in number of mental disorders truly been a product of scientific discovery? Does the classification system truly benefit the treatment of suffering? Or has the psychiatric community convinced us that the DSM serves more than a pragmatic purpose, when pragmatism seems to be its only purpose? These are important questions that will be addressed at a later time. For now, if the DSM has a place in the future progression of treatments, it should limit the current

13

emphasis on behavioral symptoms. It should include more investigation into biological and social factors influencing suffering, and provide effective methods of treatment. Most importantly, the DSM should negate common stereotypes of mental illness, and aim to empower those suffering.

Since the 1950's, pharmaceutical drugs have become a billion dollar industry. In a brilliant exploration into the globalization of the American psyche, Watters (2010) mentions that Western drug companies "spend billions marketing medications for mental illness" (p.3-4). Marketing is not only restricted to the United States, but has spread globally. Despite the obvious side-effects of anti-psychotic drugs like chlorpromazine, they have remained the staple of psychiatric treatment for schizophrenia. Psychiatric hospitals were extremely packed in the 1950's with over 500,000 patients. However, by the 1990's Mckenzie et al. (2008) states that the population of psychiatric patients had fallen to about 100,000 (p.4364-7). This decrease in psychiatric patients is not due to a decrease in mental illness, but rather the movement of deinstitutionalization. Lamb (1984) explains how the decrease in psychiatric patients created significant consequences, such as an increase in the homeless population. People who were mentally suffering were now more susceptible to becoming homeless or incarcerated. After the 1950's, treatment of schizophrenia had thankfully moved away from sterilization and lobotomy. However, the progress of treatments since the inception of anti-psychotic drugs can not be considered a success story. Those experiencing schizophrenic suffering today are in more need than ever for the psychiatric community to revolutionize, and progress treatments further.

Chapter 2: Crisis Within the Psychiatric Paradigm

Fortunately, the psychiatric paradigm has continuously been challenged by dissenters throughout history. Although dissenters have long been the minority, recently there has been a significant growth in the movement away from the psychiatric paradigm. This movement greatly developed during the 1960's anti-psychiatry movement, and has since expanded to work within the system it defies. The most important claims of this movement can be summarized as follows:

1) The discovery, or invention, of schizophrenia was based on invalid and unreliable methods of Kraeplin and Bleuler. Despite this, the psychiatric paradigm continuously affirms that schizophrenia is a real disorder. If Kraepelin nor Bleuler never discovered schizophrenia, then who did?

2) Affirming schizophrenia as a real disorder contributes to the misdiagnosis and over-diagnosis of those suffering. Assuming a hypothesized disorder is the source of suffering   causes psychiatrists to overlook others factors potentially contributing to suffering. This includes substance abuse, trauma, and socioeconomic factors.

3) More attention must be given to the personal experiences and cultural influences of those suffering. Schizophrenia is not a disease mediated through culture, but rather a form of suffering tied together with culture and personal experiences.

4) Biological factors are not denied. However, to label someone with a disease should require more evidence than behavioral symptoms. Describing a disease in terms of behavioral symptoms does little to progress biological components. Without becoming reductionist towards physiology, more research is needed to progress physiological treatments that do not have profound side-effects.

5) Further, when one is misdiagnosed with schizophrenia, this can perpetuate suffering due to the stigma that comes along with the label of mental illness.

6) Most importantly, the future progression of treatments depends on the movement away from drugs and the schizophrenic label. Treatments should not perpetuate suffering, but serve to support and empower those suffering

Thomas Kuhn (1962) investigated the structures of scientific revolutions. Kuhn asserted that the progression of science was heavily influenced by sociological and cultural

15

factors. According to Kuhn, science is conducted within a given paradigm; the assumptions, discourse, materials, methods, and so on that guide the researcher's practice. He proposed two essential characteristics of paradigms; "their achievement was sufficiently unprecedented to attract an enduring group of adherents away from competing modes of scientific activity. Simultaneously, it was sufficiently open-ended to leave all sorts of problems for the redefined group of practitioners to resolve" (p.10). In the case of the psychiatric paradigm, Kuhn's characteristics hold true. The psychiatric paradigm attracted a group of followers, and left many questions open-ended. For example, researchers have spent decades searching for genetic and biological components of schizophrenia. By assuming schizophrenia is a disease with biological markers, the psychiatric paradigm created an open-ended problem that researchers have pursued for years. Although paradigms serve as the foundation guiding future research, paradigms do not always gain acceptance from everyone.

During the 1960's, major developments in the anti-psychiatry movement vocally opposed the psychiatric paradigm. Kuhn's model of scientific revolutions suggests that a paradigm will flourish, until it is replaced by a more progressive paradigm. What causes a paradigm shift to occur? According to Kuhn, scientists work diligently to discover phenomenon that support their paradigm. However, discoveries that oppose the existing paradigm are often overlooked; "by ensuring that the paradigm will not be too easily surrendered, resistance guarantees that scientists will not be lightly distracted and that the anomalies that lead to paradigm change will penetrate existing knowledge to the core" (p.65). For example, this excerpt from Whitaker gives one example of how the psychiatric paradigm dealt with anomalies;

16

"Evidence that neuroleptics were making people chronically ill showed up fairly early. In 1967, NIMH investigators reported on one-year outcomes for the 270 patients in its earlier six-week study that had declared neuroleptics to be anti-schizophrenic drugs. Much to their surprise, the patients that had not been treated in the hospitals with drugs "were less likely to be rehospitalized than those who received any kind of the three active phenothiazines." The researchers, scrambling to come up with an explanation for this finding, speculated that perhaps hospital staff during the initial trial had felt sorry for the placebo patients (because they weren't getting well as fast as the drug treated patients) and thus had given them "some special quality in care, treatment, or concern" that led to the better one-year outcomes. It was an explanation that revealed more about the researchers than the patients: The NIHM investigators simply couldn't conceive of the possibility that neuroleptics were harming people" (p.181)

This example reveals how there is often resistance from scientific communities when anomalies provoke their paradigm. Resistance occurs along with reinterpretation, as in this example the investigators tried to explain the results in a way that still supported their paradigm.

According to Kuhn, anomalies alone are not enough to catalyze a full paradigm change. However, when the awareness of anomalies has "lasted so long and penetrated so deep [then] one can appropriately describe the fields affected by it as in a state of growing crisis" (p.67). States of crisis demand "large-scale paradigm destruction", and "the solution to each of them had been at least partially anticipated during a period when there was no crisis in the corresponding science; and in the absence of crisis those anticipations had been ignored." (p.67,75). Periods of crisis are therefore necessary components of scientific progress. They serve to challenge deteriorating paradigms, and provide new means for approaching a given problem. If the crisis is resolved, the result is a scientific revolution that abandons the previous paradigm in favor of a new progressive paradigm. In the case of the psychiatric paradigm, enough anomalies arose

by the 1960's to influence the creation of the anti-psychiatry movement. This marked the inception of a full blown crisis period. Despite the inception of crisis occurring 50 years ago, the psychiatric paradigm remains in a crisis period today. The psychiatric paradigm has successfully resisted a complete revolution for multiple reasons. However, dissenters continue to attack the psychiatric paradigm, and even work from within it to defy it from the inside. Ultimately, this section will investigate the main claims of anti-psychiatry to reveal why the psychiatric paradigm is in a state of crisis, and why the resolution of this crisis is essential to the progress of treatments.

Reliability and Validity

I will be investigating four critiques of schizophrenia and the psychiatric paradigm. The first critique relates to claims (1) and (2) noted above. If Kraepelin and Bleuler never reliably diagnosed schizophrenia, then the validity of schizophrenia should be put into question. Consider this excerpt from Bentall (1990);

> "For all these years researchers have been chasing a ghost within the body-politic of psychiatry…the concept of schizophrenia was full of contradictions at birth; perhaps it remains full of contradictions now. Put simply, it is possible that schizophrenia is not a meaningful scientific concept and that it should therefore be abandoned along with all the other meaningless concepts…which have been cast aside by scientists during crucial periods of scientific progress…The current state of schizophrenia research (many variables implicated, none conclusively) is precisely what would be expected to result from the traditional schizophrenia researcher's strategy of comparing heterogeneous groups of 'normals' with equally heterogeneous samples of 'schizophrenics'" (p.24)

Reliability of a diagnostic system refers to its ability to consistently account for a given phenomenon. If schizophrenia is a reliable disorder, then a patient diagnosed with schizophrenia by one psychiatrist, should also be diagnosed with schizophrenia by all

other psychiatrists. In psychology, reliability is a precondition for validity. Validity has multiple components, but most importantly it refers to the realness, meaningfulness, and usefulness of phenomenon. Again consider Bentall;

> "The symptoms of a hypothesized disorder should correlate with each other - a patient having one symptom of schizophrenia would have a high probability of experiencing other symptoms of the alleged disorder. Moreover, on the basis of diagnosis the clinician should be able to predict the course and outcome of the disorder, and whether or not it is likely to respond to particular treatments. Also, there should ideally be some relationship between diagnosis and etiology " (p.25).

Due to the diagnostic system operationalizing schizophrenia with behavioral symptoms, these sets of criteria serve as the foundation for schizophrenic reliability. If these symptoms are assumed to be the most predictive sign of schizophrenia, then clinicians should be able to reliably diagnose patients based on this criteria. The modern diagnostic criteria for schizophrenia has remained rather consistent since the 1950's. However, a large reliability study by Hunt et al. (1953) found that consistency for schizophrenia was only 37%. Two decades later, Copeland et al. (1971) gave 134 US and 194 British clinicians a description of a patient. While 69% of US psychiatrists diagnosed schizophrenia, only 2% of the British clinicians did so. Some of the most elaborate experiments were conducted by Rosenhan (1973), who admitted 'normal' people into psychiatric hospitals. These pseudo-patients complained of hearing voices, but this was the only faked symptom as they otherwise acted calm and 'normal'. All patients were admitted to psychiatric hospitals, and all but one were diagnosed with schizophrenia. Once the pseudo-patients were inside, they stopped exhibiting symptoms and started taking notes on the behavior of the hospital staff. Many pseudo-patients commented on the dehumanizing actions of nurses towards patients. It was estimated

that nurses only spent an average of 6.8 minutes a day with each patient. Rosenhan

(1975) then ran the experiment in reverse, telling a psychiatric hospital that at some

point in the next 3 months he would have one or more pseudo-patients admitted. No

pseudo-patients were actually sent, yet of the 193 new patients the staff identified 41 as

potential pseudo-patients. Rosenhan comments, "the facts of the matter are that we have

known for a long time that diagnoses are often not useful or reliable, but we have

nevertheless continued to use them" (p.257). Although the American Psychiatric

Association has attempted to make criteria more reliable, the criteria used today is

practically the same criteria used since the 1950's.

If the reliability of schizophrenia is unsound, this would predict the validity

would also be baseless. There is a tendency for clinicians to speak of schizophrenia as

an independent neurological disorder. However, this tendency is based in minimal

evidence, as few clinicians would claim to know with certainty the causes of the

disorder. If schizophrenia is a valid disorder, then symptoms should correlate with each

other. The World Health organization performed a study (1973) in which a cluster

analysis was performed on patients suffering from various disorders. Clustering served

to group together patients who experienced the most similar symptoms. They found that

"clusters are defining different and more homogeneous groups than are the clinical

diagnoses", and "patients diagnosed as schizophrenic are distributed in all clusters"

(p.350). This illustrates the problem of comorbidity with psychiatric disorders. Many

people diagnosed with schizophrenia often fit the criteria for other disorders. In fact,

Ellason and Ross (1995) found that people diagnosed with dissociative identity disorder

have more schizophrenic symptoms than those diagnosed with schizophrenia. Read et

20

al. (2002) notes that schizophrenia correlates with "depression, obsessive-compulsive disorder, panic disorder, personality disorder, substance abuse, post-traumatic stress disorder, and anxiety disorders" (p.48). Ideally, if schizophrenia was an independent disorder, then we would not expect many people to be suffering from a multitude of disorders. Further, the validity of schizophrenia rests on its ability to predict its course, as well as to predict effective responses to treatment. However, both the course of schizophrenia and its response to treatment have been demonstrated to be highly variable. Despite Kraepelin's assumption that schizophrenia is a degenerative disease, a long tern study by Harding et al. (1987) found that 82% of patients had not been back to a hospital, 40% were employed, and 68% had few or no symptoms. Further, Kendell and Brockington (1980) found that symptoms were poor predictors of outcome after 6 years.

Ultimately, the lack of reliability and validity in regards to schizophrenia has led researchers to challenge the utility of the concept. If schizophrenia does not serve to describe a homogeneous group of people experiencing the same brain abnormality, then is schizophrenia a useful scientific concept? The answer to this question will be developed continuously throughout the rest of the paper. For now, it is important to recognize using an unreliable and invalid scientific concept leads to consequences for those suffering. Perhaps most directly, it leads to the over-diagnosis and misdiagnosis of those suffering. As Whitaker explains;

> "Numerous studies detailed just how eager American psychiatrists were
> to make a diagnosis. A researcher who reviewed Manhattan State
> Hospital's 1982 case records determined that 80 percent of the
> 'schizophrenic' patients there had never exhibited symptoms necessary

to support such a diagnosis. Nationwide, it was estimated that more than 100,000 people had been misdiagnosed" (p.169).

Being diagnosed with a mental illness can have a profound effect on one's psyche. If the schizophrenic concept is invalid and unreliable, then many people diagnosed with schizophrenia have likely been labeled so unjustly. The effects of misdiagnosis will be later explored in the section on labeling theory. For now, misdiagnosis reflects the reliance on behavioral symptoms to diagnose mental illness, as opposed to inspecting the physical brain or the complex psychosocial factors of the individual. Focusing on symptoms blinds the clinician from other sources of suffering.

Cultural and Social Differences

It is often assumed that schizophrenia is a universal human disorder mediated through culture. For example, schizophrenics outside the US would not likely experience delusions of the CIA following them, because the CIA is not relevant in their culture. Cultural variation is thought to be noise, indicative of a deeper biological disease. However, some cultural psychologists have suggested that instead of culture being a medium to express deeper brain functions, rather culture is deeply tied together and inseparable from brain functions. This is not so surprising considering that brains primary functions involve processing the environment. When referring to culture, I use a broad definition essentially including anything occurring in one's environment. Cultures are not stagnant concepts, but rather change over time. Further, people within the same culture can interpret that cultural differently. The role of cultural importance is often overlooked by clinicians when diagnosing schizophrenia. Understanding an individual's personal and cultural context can help reveal sources of suffering.

22

Cultural influences are most prominent in regards to mental illnesses defined as culturally-bound illnesses. These illnesses are described as forms of suffering that are accepted in certain cultures but not others. Further, these illnesses are thought to be a manifestation of cultural expectations, rather than a biological foundation. Culturally-bound illnesses are often distinguished from universal mental disorders, although the distinction is not well defined. For example, dhat syndrome is a disorder in India that involves men suffering from the loss of semen. This reflects the belief in India's culture that semen is a precious resource. Although there is no biological foundation for the disorder, it can cause immense suffering for the individual. However, Americans do not classify dhat syndrome as a disorder because semen is dispensable in American culture. This illustrates the prominent role of cultures in defining what classifies a mental illness. Western society is no exception, as some examples of culturally-bound illnesses include hysteria, attention-deficit disorder, and eating disorders. For example, eating disorders don't develop in societies that value heavier women as a sign of vitality. Eating disorders developed in the West partly because it provided an environment in which slenderness was seen as the ultimate aesthetic value. The behaviors of eating disorders are thought to be derived from cultural expectations rather than biological properties. It is important to recognize that people do not choose to develop an eating disorder, but the expectations of one's culture can influence one's subconscious into expressing accepted forms of suffering. While schizophrenia is generally not seen as a culturally-bound illness, it is important to investigate cultural values and expectations that may influence the expression and diagnosis of schizophrenic suffering.

Expectations of a culture can profoundly influence schizophrenic suffering. For example, Watters (2010) explains how "those living in urban settings in the United States and Europe appear to suffer more often from the disease than those living in the country or suburbs. These curious spikes in the disorder remain even when researchers took migration, drug use, and poverty out of the equation" (p.136). There is something about living in the city that influences a higher prevalence of schizophrenia. Although no absolute consensus exists as to why rates are higher in cities, there is certainly a connection between schizophrenia and city life. Further, the expectations of culture can also influence discrimination against others. Many studies have confirmed that a disproportional amount of African Americans and poor people are diagnosed with schizophrenia. Whitaker explains that "a 1982 study of 1,023 African Americans said to be schizophrenic determined that 64 percent didn't exhibit symptoms necessary" (p.173). On top of that, African-Americans were more likely to be committed to a psychiatric unit against their will. It is also mentioned that people with lower socioeconomic status had eight times the risk of being diagnosed with schizophrenia; "behaviors and emotions that can lead to a diagnosis of schizophrenia - hostility, anger, emotional withdrawal, paranoia- go hand in hand with being poor" (p.173). The racial and classist disparity that haunted asylums of the 19th century, remains today.

One of the most important blows to the psychiatric paradigm regarding schizophrenia came when the World Health Organization published their controversial pilot study on schizophrenia (1967). This study investigated schizophrenics from different countries and measured many variables influencing the course and outcome of schizophrenia. The most surprising finding from this study was that although rates of

schizophrenia appeared to be similar in most countries, the durations and outcomes of

schizophrenia were significantly worse in developed industrialized countries. The study

has been replicated multiple times and yielded parallel results each time. Such results

sparked the question, why would outcomes of schizophrenia be worse in developed

countries that presumably have better experts and better medication?

There have been a number of hypotheses to explain the WHO results. Heine's

(2012) cultural psychology textbook lists three of the leading theories:

> 1)   "People in less developed countries tend to have a more fatalistic attitude and less of a primary sense of control, which may lead them to be less blameworthy toward people with schizophrenia (Barrowclough & Hooley, 2003)" (p.483).
>
> 2)   "Beliefs in possession by spirits are far more common in many less developed societies, so a person who claims to feel as though they're hearing voices or are possessed may be viewed as less problematic (Evans, 1992)" (p.483-4)
>
> 3)   "The stronger sense of community felt in many less developed societies means that those suffering with schizophrenia are less likely to be left on their own, and thus are less likely to end up being homeless" (p.484)

Further, Watters (2010) dedicates an entire chapter of his book investigating the

problematic results of the WHO study. He describes his time spent with anthropologist

Juli McGruder, who was researching schizophrenia in Zanzibar. McGruder was

interested in the emotional tenor of families living with 'schizophrenic' relatives.

Watters mentions McGruder was also interested in how local ideas about mental illness

"were beginning to intermingle and sometimes compete with the imported Western idea

that mental illnesses were caused by biological brain malfunction" (p.132). McGruder

was confident that "there were enough variations to suggest that the disease was shaped

by something besides the purely genetic or biological" (p.134). By closely working with

25

families affected by 'schizophrenia', McGruder set out to discover "what ideas and beliefs do family members in developing nations use to understand the delusional behaviors of a loved one? How do they talk about this behavior - what specific words and ideas do they employ? And, critically, how does the local understanding of the illness impact the beliefs, behaviors, and self -conception of the ill family member?" (p.140).

Some of the answers to the questions McGruder investigated can be illustrated by the story of Hemed and his daughter Kimwana. McGruder worked closely with Hemed's family in Zanzibar. It is mentioned that "the period in which Hemed began to experience symptoms of schizophrenia was, not coincidentally, a time of political upheaval on the island" (p.142). Watters explains that "such an onset of schizophrenia can be explained by the stress-diathesis model, the theory that biological factors make one vulnerable to schizophrenia, but stress in one's environment may set off the illness" (p.143). Kimwana's stress manifested when she entered the workforce at a time when drastic change was occurring for women on the island. Watters describes that "much of the torment of having these male presences in her head related to Islamic rules of female modesty" (p.146). Despite having two members of the family suffering from psychotic symptoms, the family "displayed an amazing tolerance for [these] difficulties" (p.148). This except about the family reveals cross-cultural differences that influence the course and outcome of 'schizophrenia';

> "McGruder rarely witnessed Amina or anyone else in the family pressure
> Kimwana into displaying normal behaviors. During periods when
> Kimwana was feeling well, for instance, Amina would report that she
> had washed dishes or swept the house. But Amina didn't assume a cause
> and an effect between productivity and wellness. This goes against some

of the basic tenets of Western occupational therapy, which suggests that the path to mental health can be found in productivity and participation in group activity. Although the family viewed her participation in household chores as a sign of health, they didn't pressure her to perform chores with the assumption that they were curative. Indeed, when Kimwana was doing poorly, the family allowed and even encouraged her to withdraw from a activity and to rest. Often, when she tried to help out during such times, her family cautioned her not to overextended herself. For the most part, however, Kimwana was allowed to drift back and forth from illness to relative health without much monitoring or comment by the rest of the family. Periods of troubled behavior were not greeted with expressions of concern or alarm, and neither were times of wellness celebrated. As such, Kimwana felt little pressure to self-identify as someone with a permanent mental illness. This stood in contrast with the diagnosis of schizophrenia as McGruder knew it was used in the West. There the diagnosis carries the assumption of a chronic condition, one that often comes to define a person. The prizing of rest over work and passive acceptance of abnormal behavior versus active encouragement or criticism were representative of an overall calm emotional tone in the household. Even on difficult days there was an air of tolerance when dealing with Hemed's and Kimwana's disturbed behavior. McGruder believed that this tone emanated not simply from personalities in this particular family but from cultural cues in Zanzibar" (p.150-1)

The story of Hemed's family reflects a broader schism related to views of psychiatric suffering. Hemed's family did not view suffering as a sensation necessitating eradication, but rather suffering was accepted as a meaningful condition of life. Their family "believed that God's grace awaited those who not only endured suffering but were grateful for the opportunity to prove their ability to endure it" (p.155). Further, the belief in spirit possession "had the counterintuitive effect of lessening the stigma attached to the behavior of the mentally ill person. It made bizarre and or disruptive behavior more understandable and forgivable" (p.157). Emotional influences have also been investigated in Western society. Multiple studies have shown how living with family with high *expressed-emotion* (EE) increases relapse rates for those suffering. EE is described as criticism, hostility, or emotional over-involvement towards a suffering

family member. Watters explains that "in a paper that aggregated the data from dozens of studies, researchers noted that the relapse rates were three to seven times greater for patients from high-expressed-emotion families" (p.153). This intense involvement from family members "springs from a hopeful engagement of the problem," but "might be the very thing that exacerbates the illness" (164). Thus, emotional tenor can have profound effects on the course and outcome of those suffering. Cultures such as Zanzibar accept suffering as a natural condition of life, which contributes to a relaxed and supportive emotional tenor. However, Americans typically invest intense emotions to try and understand and eradicate suffering, which may contribute to additional stress that perpetuates suffering.

Cultural variation is one of the most important factors to recognize when treating schizophrenic suffering. If schizophrenia were a universal disease with a primarily biological foundation, we would expect the course and outcome to be similar across cultures. However, this is far from the truth as outcomes of schizophrenia vary widely across cultures. Perhaps, the universality of psychotic experiences instead reflects a cultural foundation, the universality of a stressful environment, which interacts with biological properties of the brain. Perhaps the distinction between culturally-bound illnesses and universal disorders is not ontologically discrete. In David Morris's brilliant exploration titled *The Culture of Pain* (1991), he challenges two of the most influential assumptions of the modern psychiatric paradigm. First, the assumption that mental and physical pain are ontologically discrete, and second that pain is best understood by medical experts. This excerpt from Morris reveals the problems with the

modern conception of pain, and asserts that pain is always intricately tied together with

culture;

> "Certainly we can take comfort in assuming that pain obeys the general
> laws of human anatomy and physiology that govern our bodies. The fact
> is, however, that the culture we live in and our deepest personal beliefs
> subtly or massively recast our experiences of pain. Normally the shaping
> force of culture and belief passes almost unobserved. Like upright
> posture, our everyday experience of the world seems so natural - so
> 'given' - that we take it for granted. It is less our pain than our culture,
> however, that draws us irresistibly toward the medicine cabinet, as if
> pills and tablets held some kind of magnetic, eternal attraction for the
> unseen torments of a bad back. The story of how our minds and cultures
> continuously reconstruct the experience of pain demands that we look
> beyond the medicine cabinet. Medicine, in fact, because of its dominant
> position in our culture, tends automatically to suppress or to overpower
> all the other voices that offer us a different understanding of pain,
> including voices of dissent within medicine" (p.2)

Trauma and Psychosis

The most imperative criticism to address is the relationship between psychosis

and trauma. Trauma can refer to many experiences and it is difficult to define. This is

because traumatic experiences are mediated through the subjective mind. What may be

traumatic for one individual, may not bother another individual. The stress-diathesis

model mentioned previously also relates to trauma. When one encounters a traumatic

and typically stressful experience, the brain (conscious and subconscious) must then

figure out effective coping strategies. The prevalence and importance of traumatic

experiences has often been overlooked by clinicians. When clinicians are immersed in

diagnosing behavioral symptoms, they ignore hearing about the life story of the

individual which can often reveal sources of suffering. Unfortunately, one of the most

common sources of trauma is childhood sexual and emotional abuse. For too long the

psychiatric paradigm has neglected the fact that sometimes trauma can directly

29

influence states of psychosis. Thus, does diagnosing someone with schizophrenia because they fit certain behavioral symptoms, truly serve a beneficial purpose if that person is obviously suffering from past trauma?

First we must establish the relationship between trauma and psychosis. Judith Herman (1992) explores the expansive impacts of traumatic experiences. The relationship between trauma and suffering has not always been denied. For example, Freud (1896) claimed that "at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience" (p.203). However, Herman describes how Freud quickly repudiated that claim because of its social and political implications (p.14). If Freud's theory was correct, then sexual abuse was an endemic in both the proletariat and bourgeois classes. After Freud denied his own theory, he was forced to reinterpret the causes of hysteria. He now believed that women fabricated their traumatic experiences, and "insisted upon exploring feelings of erotic excitement, as if the exploitative situation were a fulfillment of desire" (p.14). Unfortunately, this was not the only time in history that women's trauma was repressed, as Herman describes that for the first half of the 20th century "to speak about experiences in sexual or domestic life was to invite public humiliation, ridicule, and disbelief. Women were silenced by fear and shame, and the silence of women gave license to every form of sexual and domestic exploitation" (p.28). Luckily, the women's liberation movement of the 1970's paved the way for women to safely speak out against sexual and domestic violence. A study conducted by Russell (1984) interviewed over 900 women and found that one in four women had been raped, while one in three had been sexually abused as

a child. The women's liberation movement would finally provide a platform, in which

women could feel safe and seek out treatment for years of repressed memories.

Herman mentions that "the ordinary response to atrocities is to banish them from

consciousness" (p.1). However, she adds that atrocities "refuse to be buried" (p.1). This

highlights a conflict between wanting to deny horrible experiences, yet struggling to

proclaim them aloud. These conflicting feelings can lead to a contrast of behaviors, on

the one hand numbness and dissociation, on the other hand hyper-alertness and reliving

the traumatic experience. The traumatic experience is not passively processed, but

penetrates deeply into the victims psyche. Abram Kardiner (1947) excerpt describes the

psychological and neurological effects of a traumatic experience;

> "The whole apparatus for concerted, coordinated, and purposeful activity
> is smashed. The perceptions become inaccurate and pervaded with terror,
> the coordinative functions of judgement and discrimination fail… the
> sense organs may even cease to function… The aggressive impulses
> become disorganized and unrelated to the situation in hand… The
> functions of the autonomic nervous system may also become
> disassociated with the rest of the organism" (p.186)

The autonomic nervous system refers to systems that manage high and low arousal

levels, the sympathetic and parasympathetic respectively. When a traumatic experience

occurs, these systems act essentially as defense systems. Research has shown that

environmental influences can potentiate alterations in the brain, which create

preferences for one system over the other. For example, Schore (2003) found that

common defenses of a more active sympathetic branch included acting out, mania, and

externalizing behaviors, while common defenses to avoid highly arousing emotions

(sympathetic branch) included denial, dissociation, and devaluation. Further, traumatic

experiences, especially continuously reoccurring ones, have been shown to effect one's

amygdala (emotional system) and hippocampus (memory system). The amygdala is a structure of the brain which, among other things, processes and triggers reactions to dangerous stimuli. Research by Bremner et al. (2005) shows that compared to a control group, those diagnosed with PTSD tend to have a more hyper-responsive amygdala. The hippocampus works closely with the amygdala in forming emotional memories. Carrion et. al. (2010) found that compared to a control group, those with trauma history were more likely to have a hypo-responsive hippocampus. The hyper-responsiveness of the amygdala and the hypo-responsiveness of the hippocampus illustrates the complicated response of the brain towards traumatic experiences. On the one hand the amygdala (emotional responses) becomes over-sensitized, while the hippocampus becomes desensitized towards the formation of memories. This is reflected by anecdotal evidence of people involved in severe auto accidents who can't remember the details of the accident, but simultaneously feel highly emotional when they get in cars post-accident.

Traumatic experiences are further complicated when the source of trauma is a fellow human being, rather than say a natural disaster. This excerpt from Herman highlights the significant relationship between victim, perpetrator, and witness;

> "It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. [They] appeal to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering…To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins the victim and witnesses in a common alliance. For the individual victim, this social context is created by relationships with friends, lovers, and family. For the larger society, the social context is created by political movements that give voice to the disempowered" (p.7-9)

Things are further complicated due to the fact that perpetrators of sexual violence are most often people that are closely associated with the victim. Intimately knowing one's perpetrator can cause profound psychological consequences for the victim. The victim is forced to evaluate how a previously trustworthy and loving individual could commit such an atrocious act. This phenomenon has been extensively studied by Pam Birrell and Jennifer Freyd (2013) who refer to it as *betrayal blindness*. Betrayal refers to when a trustworthy associate breaks the bond of trust by committing an atrocious act. Blindness refers to when victims are unconsciously encouraged to look away from abuse, in order to maintain stability in the relationship with the perpetrator. Children are especially susceptible to betrayal blindness because children are highly dependent on their caregivers. Although it may seem counterintuitive that an effective coping strategy would be to stay with the perpetrator, evidence shows that betrayal blindness is much more prevalent and revealing than anticipated. For example, Freyd et al. (2001) found that people who experienced sexual or physical abuse from a caretaker showed significant memory impairment compared to those abused by a non-caretaker. Further, Gobin&Freyd (2009) found that childhood trauma with high betrayal predicts revictimization in adolescence and adulthood. Finally, Gomez and Freyd (2013) discovered a relationship between betrayal and hallucinations. Three groups (High Betrayal, Medium Betrayal, No Betrayal) were measured for their rates of tactile, auditory, and visual hallucinations. The results showed that 72% of members in the high betrayal group experienced hallucinations, compared to 48% of medium betrayal members and only 24% of no betrayal members. It is important to recognize the

expansive impacts of traumatic experiences, as they can deeply penetrate and alter the life course of the individual.

The relationship between trauma and psychosis is undoubtedly revealing. A study by Lataster et al. (2006) surveyed over 1,000 young students and measured their exposure to sexual trauma and bullying. The study found that both sexual trauma and bullying were associated with psychotic symptoms. A longitudinal study conducted by Arseneault et al. (2011) discovered children who were exposed to intentional acts of abuse were more likely to experience psychotic symptoms than those only exposed to unintentional harm. Further, Lardinois et al. (2011) found a significant interaction between childhood trauma and daily life stress in psychotic patients. This finding suggested that a history of childhood abuse is associated with increased sensitivity to stress. Traumatic experiences do not only influence the development of psychotic symptoms, but they can also influence the content of symptoms. For example, Thompson et al. (2010) found "higher rates of attenuated psychotic symptoms of a sexual content in those with a history of sexual trauma" (p.88). This finding suggests that people experiencing auditory hallucinations often hear the critical voices of their abuser. Thus, the content of hallucinations and delusions which has for long been ignored by clinicians, may actually have symbolic meaning and deep connections to past traumatic experiences. This brings up the question, why might psychotic symptoms be a normal and effective reaction to trauma? The most compelling argument is that trauma induces hyper-vigilance, an enhanced state of sensitivity accompanied by behaviors which purpose is to detect threats. Herman (1992) explains that traumatized people "have an extreme startle response to unexpected stimuli" especially if the stimuli

is related to the traumatizing event (p.36). After trauma has occurred, and especially if it is reoccurring, the brain may develop a preference for hyper-vigilance, in order to notice threats before they occur. Perhaps symptoms of schizophrenia are not symptoms of a disease, but rather deeply rooted responses and expressions of the brain towards traumatic experiences.

Unfortunately, the DSM does not describe any relation between trauma and psychosis, which leads to an absence of dialogue about trauma when diagnosing people with psychotic symptoms. The psychiatric system ignores evidence that trauma can influence the onset and content of psychotic symptoms. Many victims are continuously tormented by their perpetrators long after the abuse has ended. For some people, it is unfathomable to imagine what it would be like to experience severe sexual trauma perpetrated by a close loved one. For others, this nightmare is reality. There is no "correct" way to respond to severe trauma. Responses and coping strategies are highly variable and occur both consciously and unconsciously. The development of psychotic symptoms may be one way the brain attempts to protect and heal itself after trauma, for better or for worse. It is important to affirm the relationship between trauma and psychosis, in order to make sure patients are not re-traumatized during treatment. Although not all people experiencing psychotic symptoms have trauma history, the prevalence and impact of traumatic experiences with psychosis commands more attention. Trauma can influence psychosis, and psychosis in itself can be traumatizing due to the stigma that is attached. The responses by others to one's psychosis and diagnosis can also in itself be traumatizing, and this is the topic that will be developed in the succeeding section on labeling theory

35

Labeling Theory

The final critique of the construct of schizophrenia I will analyze comes from labeling theory. Many scholars have investigated the consequences of labeling a group of people. Labeling theory's foundational claim is that the terms used to classify an individual, influence the identity and behavior of those classified. Further, labeling can cause groups outside the label to infer that labeled groups are more homogeneous than they really are. Proponents of labeling theory have primarily investigated the consequences of labeling deviance from normality, such as crime and homosexuality. In regards to the psychiatric paradigm, labeling primarily serves a pragmatic purpose for clinicians to group together similar patients. Patients who are labeled can then seek out treatment that corresponds with their specific label. However, the stigma attached to certain labels can influence suffering. If the overall effects of labeling cause further suffering, then the system designed to support those suffering actually perpetuates suffering. The schizophrenic label undoubtedly helps clinicians converse and classify, but does the schizophrenic label truly benefit those suffering?

First we must understand how labels influence the identity and behavior of those classified. Ian Hacking's (1999) exploratory paper on *making-up* people argues that it "is not that there was a kind of person who came increasingly to be recognized by bureaucrats or by students of human nature but rather that a kind of person came into being at the same time as the kind itself was being invented. In some cases, that is, our classifications and our classes conspire to emerge hand in hand, each egging the other on" (p.165). Ironically, one of Hacking's most prominent examples of this phenomenon is multiple personality disorder, a close relative to schizophrenia. Hacking claims that

"multiple personality as an idea and as a clinical phenomenon was invented around 1875: only one or two possible cases per generation had been recorded before that time, but a whole flock of them came after" (p.162). Multiple personality disorder was not a disease lurking in nature waiting to be discovered, but rather had to be invented by clinicians and animated by patients. This position does not deny that behaviors resembling multiple personality may have existed throughout history. However, it asserts that the invention of multiple personality disorder as a *real* form of being, simultaneously created new ways for disturbed people to be, to behave, and to express suffering. The clinical label served as verification that certain behaviors were symptoms of a disease that required clinical analysis and treatment. Once multiple personality disorder was invented, it became a cultural accepted and verified behavior to express suffering.

Acknowledging multiple personality disorder as a recent phenomenon whose labeling served to increase its prevalence, does not infer that people who suffer from multiple personalities are "making-up" or fabricating their disorder. Instead, there is much evidence that multiple personalities are a form of dissociation that serves as a coping strategy for childhood sexual abuse. Birrell and Freyd (2013) mention that "if a little girl is sexually abused at night, and during the day her family behaves as though nothing happened, the little girl must put that knowledge aside in order to stay in her family" (p.99). Dissociation serves as a forgetting mechanism; when a child unconsciously creates a new personality, it does so to protect its "main" personality from the horrors of sexual abuse. For example, Birrell and Freyd describe the story of Cathy who "learned to check out from the extreme pain and confusion when her

37

surroundings didn't support her" (p.100). Cathy continues "the biggest betrayal for me was the normalization, that there's this incredible lie going on, that parents are suppose to love you and keep you safe, and in my experience those were the most dangerous people" (p.97). Birrell and Freyd add that understanding the mechanisms of dissociation "makes us begin to question whether it is a real mental disorder or whether it is a normal and creative response to what really is the disorder: the betrayal of intimate and what should be loving bonds" (p.99). In any case, once multiple personality disorder was a clinically verified disorder brought into public awareness, a label now existed for those suffering to latch onto and creatively express their suffering.

The *making-up* of schizophrenia shares a similar story. It is likely that states of psychosis have existed throughout human history, but whether or not these states were beneficial, damaging, extraordinary, or normal has yet to be determined. However, once schizophrenia was invented, its label served as clinical verification that psychotic experiences were abnormal symptoms of a disease. Psychosis, like dissociation in multiple personality disorder, is likely a mechanism of the mind and not an invention. However, schizophrenia is an invention that simultaneously created new ways for those experiencing psychosis to be, to behave, and to express suffering. Those experiencing psychotic episodes were now part of a group of people known as 'schizophrenics'. When an individual is defined by an illness, the connotations attached to the illness are simultaneously attached to the individual. The psychiatric domain has moved away from using the term 'schizophrenics' as the DSM-IV "instead uses the more accurate, but admittedly more cumbersome 'an individual with schizophrenia" (p.xxxi). Despite the attempt by the psychiatric domain to reduce stigma using the term 'with', the

negative connotations of schizophrenia remain attached to the individual 'with schizophrenia'. Being diagnosed with schizophrenia is never likely an enjoyable experience for an individual. The heterogeneous nature of psychotic experiences is not reflected in the diagnosis of a singular schizophrenic label. How then did the schizophrenic label, in a sense, create schizophrenics, and what are the consequences of diagnosing an individual with the schizophrenic label?

Some of these consequences have already been discussed: the increase in American asylum patients during the 1870-1950's, how an unreliable and invalid method of diagnosis leads to misdiagnosis, and the profound side-effects of psychotic drugs. It is noteworthy to add how these three examples all perpetuate suffering; being locked forcefully in an asylum, being misdiagnosed with a stigmatized mental illness, and being fed brain-altering medication can all profoundly damage one's psyche. Labeling theory in regards to mental illness was primarily developed by Thomas Scheff (1966) who argued that the label of mental illness was both a social construction and a social role. Although Scheff originally overlooked some biological and psychological factors, his theory has since been revised to include interdisciplinary factors. Scheff asserts when an individual is labeled with a mental illness they are placed in a stigmatized status, which can lead to relational and institutional discrimination. Further, he argues expectations embedded in the illness can act as a social force which pressures the labeled individual into unconsciously fulfilling these expectations. Consequently, labels serve as a self-fulfilling prophecy, "whereby people have expectations about what another is like, which influences how they act toward that person, which causes that person to behave consistently with people's original expectation, making the

39

expectations come true" (Aronson 2010, p.504). Originally, Scheff believed that labels can directly cause 'mental illness'.

A "modified-labeling theory" was proposed by Link et al. (1989) after they conducted an experiment to test Scheff's theory. Over 500 community residents and psychiatric patients were placed in groups and tested on many different variables. The results showed that "in the course of being socialized, individuals develop negative conceptions of what it means to be a mental patient and thus form beliefs about how others will view and then treat someone in that status" (p.419). Modified-labeling theory departs from Scheff's model; "our approach does not assign to labeling the power to create mental illness directly. Instead, we view labeling and stigma as possible causes of negative outcomes that may place mental patients at risk for the recurrence or prolongation of disorders" (p.404). Their results showed a significant relationship between labels and withdrawal. Labeling led people to "withdraw from social contacts that they perceive as potentially rejecting", and the researchers add that "such strategies can lead to negative consequences for social support networks, jobs, and self-esteem" (p.400). Further evidence for modified-labeling theory comes from Wright et al. (2000), which ran a 2 year followup study on recently deinstitutionalized patients. The "results indicate that social rejection is a persistent source of social stress for the discharged patients" and that "these experiences increase feelings of self-deprecation" (p.68). Although labels can not directly cause a mental illness, labels can significantly influence and damage the psyche of the labeled individual. The problem of labeling is complicated further when the label is assumed to be of biological nature. Mehta (1997) ran an experiment in which subjects were paired with confederates who were labeled

with either a biological mental illness, or a mental illness caused from childhood experiences. The results showed that people increased the severity of electric shocks at a faster rate to those given a biological label. Mehta explains;

> "If we regard those with mental disorders as sick, we may adopt a patronizing attitude toward them. While believing that we ought not to blame the afflicted for their failure to measure up, we may also believe that people with mental disturbances, like children, must be treated firmly. They must be shown how to do things and where they have erred. Hence the harsher treatment." (p.416)

Critics of labeling theory argue that labels are beneficial because they can guide patients toward treatment. However, does labeling actually serve to help determine proper methods of treatment, is the label a necessary component of treatment? No, there is no singular method of treating schizophrenia because the heterogeneity of psychotic experiences requires a variety of treatments personalized toward the specific suffering individual. Despite any pragmatic value of labeling, the consequences of labeling schizophrenia outweigh any benefits. Labels influence clinicians to focus on eradicating behavioral symptoms, while ignoring the life story of the individual. For example, according to the criteria of the DSM two individuals could be labeled schizophrenic who share no common symptoms. Sometimes what clinicians label as schizophrenia is really normal reactions to extreme events such as trauma, other times there may be a more organic basis. The variability within psychotic experiences should not be subjected to a singular label. To label someone with a biological illness should require more evidence than behavioral symptoms; we don't diagnose cigarette smokers with lung cancer without at least looking at their lungs. Evidence has shown that labels not only damage the individual, but damage the ability for society to see the individual as more than their label. Page (1977) found that "persons identifying themselves as mental

patients were refused rooms for rent significantly more often than were persons using

no mental illness identification" (p.85). Further, Stuart (2006) explores the

disproportional amount of unemployment effecting the mentally ill. In conclusion, this

except from Watters (2010) shed light on the effects of naming a disease;

> "Individuals in a given place and time will react to illness similarly, in other words, because they share the same limited repertoire of cultural scripts for how to play their part. The different ways that cultures communicate expectations for behavior are often quite subtle. Seemingly small differences, such as the disease's name, can make a difference. Jenkins noticed, for instance, that Mexican American families in southern California, who had lower expressed emotion scores than Anglo-American families tended to use the term *nervios* to describe the illness of the relative with schizophrenia…*Nervios* is a catchall diagnosis for feelings of disquiet or distress…Jenkins saw the use of the word was part of a strategy by which the family jointly downplayed the gravity of the illness. *Nervios* carried little of the dire connotations an Anglo-American would associate with schizophrenia. *Nervios,* like spirit possession, is thought of as a transitory state. This allowed relatives and the ill family member to regard periods of remission in a more favorable light. This hopeful naming also fostered feelings of empathy. Many of the Mexican-American family members in one of Jenkin's studies told her that they too had suffered from *nervios,* in a milder form, and so could empathize with the relative's distress…The label and its connotations allowed family members to keep the relative within the fold." (p.160-1)

.

Chapter 3: Progress through Support and Empowerment/Conclusion

Ultimately, the concept of schizophrenia and the methods of its treatment can perpetuate suffering. If this is true, then the quality and utility of the schizophrenic concept should be put into question. The main assumption of this paper, stated in the introduction, is that the primary role of the medical system should be to support and empower those suffering. How then can the "making-up" of schizophrenia, and all of its extensions, be used to empower rather than damage those suffering?

First, it is necessary to evaluate the current state of crisis within the psychiatric paradigm, in order to suggest actions which modify the current schizophrenic model. This task is essentially connected to the question of scientific progress which Kuhn so deeply investigated. It is important to recognize that Kuhn distinguishes "mature sciences" such as physics or biology, from "soft sciences" such as philosophy or psychology. This distinction is necessary because mature sciences and soft sciences progress uniquely. According to Kuhn, 'scientific progress' is a redundant notion because progress is an essential characteristic of science; "viewed from within any single community, however, whether of scientists or of non-scientists, the result of successful creative work is progress" (p.162). He explains that "normally, the members of a mature scientific community work from a single paradigm", and that "the absence at most times of competing schools that question each other's aims and standards makes the progress of a normal-scientific community far easier to see" (p.162-3). The progress of mature science is easier to see because once a paradigm shift has completed, competing schools of thought dissolve and a singular core paradigm serves as the foundation for future research. For example, the theory of evolution altered and

hijacked the paradigm of biology. Although biologists may argue about the details of evolutionary theory, it would be challenging for any biologist to see the world in any terms other than evolution.

Progress within soft science is not as straightforward. Kuhn states "if we doubt, as many do, that non-scientific fields make progress, that cannot be because individual schools make none. Rather, it must be because there are always competing schools, each of which constantly questions the very foundations of the others. The man who argues that philosophy, for example, has made no progress emphasizes that there are still Aristotelians, not that Aristotelianism has failed to progress." (p.162-3). Although here Kuhn groups together non-science with philosophy, it is important to recognize that there should be a distinction between non-science and soft science. Kuhn is a bit harsh in considering philosophy and psychology as non-science, as both domains utilize and benefit from ideas propagated through science. While a single paradigm tends to guide mature science, soft sciences are characterized by multiple competing schools of thought which debate over fundamentals. The student studying soft science "has constantly before him a number of competing and incommensurable solutions to these problems, solutions that [they] must ultimately evaluate for [themselves]" (p.165). Although soft sciences produce paradigms, a single paradigm is never likely to be completely accepted by its scientific community. This is because the questions concerning soft sciences tend to be more subjective, and thus more open to interpretation. While periods of crisis tend to be rare and dramatic in the progression of mature science, soft sciences are characterized somewhat as being in a perpetual state of crisis.

44

In the case of the psychiatric paradigm, voices of dissent have continuously challenged the paradigm throughout its history. Although the psychiatric paradigm never gained universal acceptance, it was accepted by the medical industry. The endorsement of the psychiatric paradigm by the medical industry legitimized the paradigm in the eyes of the general public, despite that it was never fully accepted by its own scientific community. Unfortunately, the paradigm was legitimized prematurely as the scientific community never established the basic research necessary to support their claims. Basic research is distinct from applied research as basic research describes the study of the fundamental aspects of a phenomenon. The development of basic research serves as the foundation in which applied research branches off. Applied research describes the utilization of basic research to create methods and techniques which further contribute to knowledge about a phenomenon.

For the psychiatric paradigm, basic research primarily focuses around biological factors while applied methods primarily involve the classification system (DSM) and treatment through pharmaceutical drugs. In the case of schizophrenia, basic research should consist of essential facts about the 'disease' such as prevalence and form. Applied research should consist of treatment and prevention methods. Notice how the knowledge of basic research should assist the development of applied methods. However, the psychiatric paradigm ignored establishing basic research and skipped to developing applied methods. For example, the creation of insane asylums manifested without much consensus about what defined insanity. Further, the invention of schizophrenia lacked basic evidence, yet much was assumed about the disorder in creating treatment methods. Ideally, basic research of a disease should include its form

45

and etiology, but schizophrenia was invented amidst mystery and has remained mysterious ever since. Before the development of basic qualities regarding schizophrenia, schizophrenia was already assumed to be a legitimate disease entity that necessitated medical treatment. By performing applied research without the foundations basic research provides, the scientific community attempts to treat schizophrenia without a fundamental understanding of what schizophrenia actually means.

This lack of connection between basic and applied research has dangerous implications for those suffering because inadequate basic research becomes the basis for diagnoses that may be illegitimate. These diagnoses then necessitate treatment that may be inappropriate, but are justified by applied research. Through the process of diagnosis and treatment, an individual is affirmed that there is something wrong with them and then reduced to becoming the object of study. This affirmation creates a dependent relationship between the patient and clinician because the clinician is believed to hold the knowledge about how to combat the disease. However, because applied treatments of schizophrenia have little basis in basic research, treatment methods are innately limited and may even add to existing problems as is the case with the profound side-effects of anti-psychotic drugs. Although the clinician tries to help the individual, overlooking the disconnect between basic and applied research hinders the clinicians ability to properly treat the individual. By acknowledging and addressing this disconnect, however, a holistic treatment can be developed that is more focused on the individual rather than the poorly-researched disease that the individual may be suffering from.

The stranglehold of the medical industry over the psychiatric paradigm has persisted for far too long. Foundations of the psychiatric paradigm were born prematurely through illegitimate methods, but have remained legitimized by the medical industry through constant reinterpretation and affirmation. This biomedical approach to mental illness creates a profitable financial flow between drug companies and psychiatry, making influence over the psychiatric paradigm more than purely scientific. Simultaneously, it creates a stigmatized environment that damages the psyche of the suffering individual. Although not all aspects of the psychiatric paradigm create negative repercussions for those suffering, enough core assumptions and methods damage the individual which reveals the necessity of creating scientific progress through paradigm reconstruction. Unlike the problems facing mature sciences, the problems facing the psychiatric paradigm deal directly with human suffering which is always in need of urgent attention and progress. Basic research is important but because those suffering are in need of urgent treatment, ultimately the most important job of the mental health profession is to enhance applied treatment methods. If schizophrenia was merely an invalid term, it could still have utility within the psychiatric realm. However, schizophrenia is not only invalid, but the term itself stigmatizes and damages the individual. Progress requires interdisciplinary communication among many more factors. I do not have the expertise or time to describe complete paradigm reconstruction. However, I will explore psychosocial approaches to reconstructing schizophrenia, which serve to empower rather than damage those suffering from psychotic experiences.

International Society for Psychological and Social Approaches to Psychosis

The perpetual state of crisis has forced dissenters to work within the paradigm they defy. This is because insurance for treatment requires a DSM diagnosis. Although dissenters may not agree with the diagnostic system, they understand that those suffering require support and that they must work within the current system in order to help. One important dissenting organization is the *International Society for Psychological and Social Approaches to Psychosis* (ISPS). During the last few months, I have attended a number of events put on by the Eugene chapter of ISPS. In this next section, I will describe the alternative approaches to schizophrenia emphasized by ISPS. Ultimately, since assumptions are made that negatively impact the individual suffering with schizophrenia, and because the basis of the disease itself is questionable, this questions the utility of the disease. This is not meant to discredit the individual suffering from psychotic experiences, but rather to empower them that they are not alone in their suffering, as many people experience psychosis who are able to successfully recover.

ISPS was created in 1956 and expanded to the United States in 1998 "to go beyond a biological-reductionist orientation and to gain a psychoanalytic understanding of the complexity of psychosis" (p.1). Their mission listed on their website consists of 5 key claims:

1) Promote the appropriate use of psychotherapy and psychosocial treatments for those suffering from psychosis
2) Support treatment that include individual, family, group and milieu approaches and treatment methods that are derived from psychoanalysis, cognitive-behavioral, systemic, psycho-educational, peer support and related approaches
3) Advance education, training and knowledge of mental health professionals in the psychological therapies and psychosocial interventions in the

treatment and prevention of psychosis for the public benefit regardless of race, religion, gender orientation, or socioeconomic status

4) Promote personal empowerment as a necessary part of recovery from psychosis

5) Promote research into individual, family, and group psychological therapies, preventative measures and other psychosocial programs for those with psychosis

These claims highlight the necessity to have an adaptable approach to therapy. Since there is high variability within psychotic experiences, different individuals will require different methods of treatment. It is important not only to analyze the psychotic experiences of the individual, but also to understand the life story and context of the individual, as this can often reveal true sources of suffering which may be influencing psychotic experiences. The job of the clinician is not to simply diagnose diseases, but to listen and understand the individual in order to provide the proper support. Working closely with ISPS member and private therapist Ron Unger, I have been able to witness firsthand the differences between the typical approach to therapy and alternative approaches. Typically, therapy consists of circular logic which in effect stagnates or even increases suffering (see Figure 1). First, a patient comes into the clinicians office looking for an explanation for these weird experiences they have had. Next, the clinician asks questions based off of diagnostic criteria which assures that these experiences are caused by an illness, schizophrenia. Then, the patient wonders how the clinician knows they have an illness called schizophrenia. Finally, the clinician replies that they can diagnose you with schizophrenia because you have had these weird experiences. Consequently, the patient may leave more confused about their experiences than when they arrived. They are now affirmed they have a biological disease, which is best treated by eradicating symptoms through anti-psychotic drugs.

Ron Unger takes a drastically different approach to his job. For Unger, the role of the therapist is not to simply be an expert who diagnoses behaviors and provides medication. Instead, the role of the therapist should be collaborative rather than authoritative. The therapist is an empathetic fellow human being, who also experiences the universal condition of human suffering, and should work together with the patient in creating a path to recovery. Since people suffering from psychotic experiences often have trouble maintaining meaningful relationships, the therapist is inclined to provide a nurturing and compassionate relationship with the patient. Focusing on behavioral symptoms of a hypothesized disease will blind the clinician from the bigger picture of the individual. One key aspect of all therapies should be to instill in the individual a sense of hope that they have the ability to recover. Treatments should go beyond simply trying to eradicate symptoms, and instead attention should be given to observable factors that either strengthen or weaken suffering. Further, the patient should be assured that their experiences are really not quite that different from what is designated as normal experiences. By opening up about his own experiences with mental disturbances, Ron assures the patient they are not alone in their suffering.

Ron Unger's story, which in some sense is shared by many others suffering from psychosis, reveals how psychotic experiences can become a source of empowerment. Ron Unger's journey to becoming a therapist developed during his childhood when he experienced early trauma. As mentioned earlier stress, trauma, and intense emotional tenor of families are all related to later psychosis. Ron explains on his webpage "as do many traumatized children, I internalized much of the oppression, resulting in a defective identity and difficulty making social connections" (p.1). Luckily, Ron began

to form relationships in college with like-minded people who "saw it as a possible

positive journey" (p.1). This led him to find work with organizations that worked

against the mental health system. However, Ron mentions that he was the lucky one

because although the basic outline of their journey was the same, "many of his siblings

did not fare as well" (p.1). This excerpt from Ron expresses how he gained

empowerment by working with people he could relate too that were often mistreated by

others;

> "What motivated me was the understanding that people similar to myself
> (including my own siblings) were being misinformed about what they
> were going through by a system that failed to understand the process, by
> a system that saw only bad in a process that I knew from my own
> personal experience could also be good. The "treatments" that were then
> given were ones that suppressed the person along with the problem, and
> that didn't open any doors to real healing, or even imagine that it was
> possible." (p.1)

When Ron became a certified therapist along with being a mental health reform

advocate, he made it his mission to address common misconceptions about psychosis in

order to develop effective and human treatment methods. Ron emphasizes the

importance of treating patients on a case by case basis. The variability of psychotic

experiences requires that therapists have adaptable treatment methods that can be

tailored to specific individuals. Further, the therapist should not add stress to the

patients condition, so using supportive discourse is also of great importance. In his

handout on common misconceptions of schizophrenia, Ron discusses the differences

between his perspective and the common perspective. First, he addresses the common

belief that schizophrenia is a brain disease. He mentions that "supposed brain

differences are very commonly found in persons not diagnosable with schizophrenia",

and "while biological differences influence vulnerability to psychotic symptoms,

probably anyone could have such symptoms given the right set of experiences" (p.1).

Next, he addresses the common misconception that schizophrenia is a chronic and

degenerative disease. He states that "long term outcome studies show most people

recover at least somewhat, and many people make a full recovery" (p.1). He adds

"psychotic symptoms may cease at any time, whoever the factors that perpetuate them

are modified" (p.1). Finally, he addresses the common misconception that medication

should be the primary tool to alleviate psychosis. However, "adding more or different

medication often just adds more harmful side effects without much or any increase in

effectiveness" (p.2). Further, "effective therapy can often reduce psychotic symptoms,

resulting in less medication being used and so fewer harmful side effects" (p.3). After

creating a safe environment in which the suffering individually feels they can safely

express themselves, Unger can then begin to start treating sources of suffering. These

next two sections will describe progressive and effective treatment methods for

psychotic experiences.

Acute and Expansive Treatment Methods

By working with ISPS and Ron Unger, I have been able to learn about treatment

methods for psychosis which aim to empower rather than damage the individual. The

biological explanation for mental illness can make the patient think that recovery is out

of their control, recovery is up to biology. However, many survivors of psychotic

experiences have been able to fully recover through personal and social coping

strategies. When speaking about contributions to mental health knowledge, Read et al.

(2004) argues that "what is surprising is the almost total absence of the voices of those

who have most direct experience of schizophrenia" (p.148). Currently, professionals in

the mental health system hold all the knowledge and power, and are expected to have a better understanding and explanation of what is going on with the suffering individual. Restricting the voices of those suffering limits empowerment of the individual, and limits scientific progress. This is especially true for schizophrenia because one of its main symptoms is hearing voices, which clinicians refuse to try to understand but rather attempt to eradicate. If progress is to be made in the psychiatric paradigm, then this requires that patient's themselves start playing a more prominent and meaningful role within research and practice. To understand "madness" we must first listen to "madness".

This section will explore two different levels of treatment methods, acute and expansive. Acute treatment methods refer to those which involve a specific individual suffering. Expansive methods refer to treatments which act at a broader scale. Both methods are critical in the attempt to support and empower those suffering from psychosis. First let's investigate acute treatments. One of the most prevalent and bothersome symptoms of psychosis is hearing auditory hallucinations, most of the time in the form of voices. Hearing voices that appear to come from outside one's consciousness can be a confusing or even traumatic experience for anyone. However, there is not such a fine line between "normal" voices and those which are defined as pathological. Many "normal" people frequently experience involuntary thoughts or even get songs stuck in their head. Mirowsky (1990) found that the subjective boundary for diagnoses "remain[s] arbitrary" and that while "most people do not have, or rarely have, most of the symptoms, everyone has some of them, and every symptom is experienced frequently by at least some people." (p.407-20). As children we are told to use our

imaginations and to even play with imaginary friends. Yet once we arrive to adulthood,

things we seem to imagine are no longer socially acceptable and can even be defined as

a symptom of a disease. However, hearing voices does not have to be seen as a

symptom necessitating eradication, as many new approaches actually encourage voice

hearers to build relationships with their voices.

The *Hearing Voices Network* (HVN) is a major organization that advocates for

mental health reform specifically in regards to voice hearing. The prevalence and

variability of voice hearers is acknowledge by the HVN on their website;

> "For some, these experiences can be comforting. For example, someone
> who is lonely may really value a voice that becomes a trusted confidant.
> A person who has recently lost someone they care about may benefit
> from talking to them at the end of the day, or smelling their
> perfume/aftershave. Others find these experiences to be a source of
> inspiration. Authors, for example, sometimes talk about how the
> characters can come to life and write the story for them. However, for
> some people these voices and visions can be extremely distressing –
> criticizing, threatening or causing confusion." (Voices and Visions, p.1)

For some, voice hearing can be a positive and creative experience. However for others,

voices can become highly criticizing making the individual highly distressed. Their

approach to hearing voices is described by this excerpt from the HVN;

> "Hearing voices has been regarded by psychiatry as 'auditory
> hallucinations', and in many cases a symptom of schizophrenia.
> However not everyone who hears voices has a diagnosis of
> schizophrenia. There are conflicting theories from psychiatrists,
> psychologists and voice hearers about why people do hear voices. We
> believe that they are similar to dreams, symbols of our unconscious
> minds. Although the Network is open to many diverse opinions we
> accept the explanation of each individual voice hearer. Traditionally, the
> usual treatment for voice hearing has been major tranquilizers,
> administered to reduce the delusions and hallucinations. However not
> everyone responds to this treatment. There are some psychiatrists and
> psychologists who now work with people who hear voices using talking
> therapies and exploring the meaning of the voices. Although this is not

yet 'the norm', this practice is increasing. As the improvement in individuals who are encouraged to talk about their voices becomes more apparent and increasing number of health professionals are beginning to understand that the key to understanding voices lies in the 'content' of the voices." (About HVN, p.1)

Ron Unger's approach is influenced by the HVN. Unger affirms his patients that he is not trying to change or get rid of any of their voices. Instead of trying to eradicate the voices, Unger attempts to mend the relationship between the individual and the voices they hear. He has noticed that many of the distressing voices heard by patients serve as metaphors for past experiences. For example, patients hearing voices such as "you're not good enough", are linked to having highly critical family members. Unger also claims that distressing voices can be linked to moments of present stress. Being conscious of one's stress is the first step towards relieving the stress. There have been many coping strategies developed for people to deal with distressing voices. Depending on the individual and the voices, certain coping strategies can be more effective. Part of all coping strategies is to develop a compassionate voice which serves to talk and consult with distressing voices. Some strategies that Unger has used effectively include being kind to the distressing voice, deliberately focusing on the distressing voice, setting specific times for one's compassionate voice to speak with distressing voices, not taking voices literally, reframing hostile voices as helping one get in touch with difficult feelings, and so on. Most importantly, rather than eradicating voices through medication which doesn't solve the deeper problems represented through voices, other strategies can be utilized that address voices as important parts of the make-up of the individual, which must be worked with rather than suppressed.

Another acute treatment method developed by Paul Gilbert (2009) is referred to as compassion-focused therapy. Gilbert defines the essence of compassion as "a basic kindness, with deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it" (p. xiii). It is not only the therapists job to be compassionate, but also to instill in the patient a sense of self-compassion. Gilbert's adds that "people with high levels of shame and self-criticism can have enormous difficulty in being kind to themselves" (p.199). This led Gilbert to explore affect regulation systems that enable individuals to feel content and safe. Gilbert's model of affect regulation systems (see figure 2) includes three major affect systems which simultaneously influence each other: threat focused, incentive/resource focused, and affiliative/soothing focused. Healthy individuals are thought to strike a balance between the three systems. Although Gilbert recognizes this is not the only way affect systems can be conceptualized, it "offers a useful heuristic for clinical thinking" (p.200). The compassion-focused model hypothesizes that the affiliative/soothing system "is poorly accessible in people with high shame and self-criticism, in whom the threat affect regulation system dominates orientation in their inner and outer worlds" (p.199). For example, "early life events may have sensitized the individuals threat protection system, leading to safety strategies that can operate automatically, as conditioned and perhaps conflicting responses" (p.200). Thus, the role of the therapist in compassion-focused therapy is to strengthen the damaged soothing affect system, in order to create a balance between all three systems.

Gilbert lists three aspects of compassionate therapeutic engagement:

1) The therapist uses the skills and expresses the attributes of compassion

56

2) The client experiences their interaction with the therapist as one that is de-shaming, compassionate and safe; ideally, the client will experience each of the attributes and skills of compassion in, and from, the therapist

3) The therapist helps the client to develop compassionate attributes and skills directed at the self

Evidence for this model is still in its infancy, however the current evidence seems highly promising. An experiment conducted by Mayhew and Gilbert (2008) practiced compassion focused therapy on a group of psychotic voice hearers. The results showed that "all participants' auditory hallucinations became less malevolent, less persecuting, and more reassuring" (p.113). This shows how compassion-focused therapy reduces the hostility of voices heard during psychosis, which is an important step towards building a productive relationship with one's voices. Developing a sense of self-compassion and strengthening one's soothing affect system is highly important for the mental health of an individual. In the highly stressful environment we live in today, it is more important than ever to dedicate time for soothing one's mind.

The final acute treatment method to be discussed was developed by Jean Baker-Miller and advanced by Comstock et al. (2008). This form of therapy, known as relational-cultural theory, "is grounded in the idea that healing takes place in the context of mutually empathetic, growth-fostering relationships" (p.279). Continuing, "in an effort to create such relationships, the RCT approach to counseling involves identifying and deconstructing obstacles to mutuality that individuals encounter in diverse relational contexts and networks" (p.279). This approach asserts that growth-fostering relationships serve as healing mechanisms towards mental health. Consequently, RCT assumes "that the experiences of isolation, shame, humiliation, oppression, marginalization, and micro aggressions are relational violations and traumas that are at

57

the core of human suffering" (p.280). This contributes to what the researchers describe as the central relational paradox; assuming all individuals experience the desire for social inclusion, "in the face of yearning for connection, which inevitably produces a heightened sense of vulnerability, individuals use strategies that result in further disconnection and isolation. Such strategies are commonly used to avoid perceived or real risks of hurt, rejection, and other forms of relational disconnection, social exclusion, and marginalization" (p.282). Therefore, it is the therapist's duty to understand the context of the individual in relation to their close relationships and culture, in order to empower the individual towards maintaining and building growth-fostering relationships.

Growth-fostering relationships are characterized by many attributes. Miller (1976) listed five major attributes:

1) Each person feels a greater sense of zest (vitality, energy)
2) Each person feels more able to act and does act in the world
3) Each person has a more accurate picture of her/himself and the other person
4) Each person feels a greater sense of worth
5) Each person feels more connected to other persons and exhibits a greater motivation to connect with other people beyond those in one's primary relationships

Therapy for an individual with psychosis can go far beyond discussing psychotic experiences. The therapist should create a growth fostering relationship between themselves and the patient, then support the patient in seeking and building growth-fostering relationships outside therapy. Further, because those with psychosis hear voices, they should be encouraged to create growth-fostering relationships between

58

themselves and their voices. The road to recovery is much easier and empowering when an individual is not alone in their suffering.

Expansive treatment methods are also crucial in progressing the empowerment of those experiencing psychosis. Again, expansive methods refer to treatments that act to empower psychosis at a broader level. Two expansive methods will be discussed: user-run services and educational programs. User-run services for psychosis refer to services that are created and operated by those who experience or have recovered from psychosis. These services can take many forms such as support groups, drop-in centers, advocacy programs, teaching services, and so on. Read et al. (2004) mentions how "when consumers/survivors come together, they often identify critical needs that are largely unmet in traditional mental health programming" (p.283). User-run services can act as a platform to build growth-fostering relationships, especially because the individuals have experienced and can relate to similar forms of suffering. Herman (1992) describes how Vietnam veterans created "rap groups" which "retold and relived the traumatic experiences of war" (p.26-7). Since Post-Traumatic Stress Disorder was not invented yet, these trauma survivors found support and comfort through each other. This reflects how many people affected by trauma or psychosis find peace and recovery through making connections with others affected by the same trauma or experience. By working with similar people who at the same time advocate and provide support for the common source of suffering, user-run services can themselves be a form of therapy and empowerment.

Lastly, another expansive method for advancing the treatment of schizophrenia is educational programs. In order for a safe and empowering environment to be created,

it will take more than purely the efforts of the psychiatric domain, but also the efforts of the general public. The misconceptions about psychosis within the general public helps foster a regressive environment for those who experience psychosis. Although the original goal of mental health literacy was to reduce stigma, the biological framework has had the opposite effect of creating a more stigmatized environment. Watters (2010) asserts that it is important to recognize "which cultural beliefs tend to exclude the sufferer from the social group and which allow the ill individual to remain part of the group" (p.176). The goal of educational programs should be to help reinstate the individual suffering from psychosis into the social group of all individuals. Educational programs can be introduced into the education system, as well as into the media via internet, television, and newspapers. Mental health awareness should not serve to create a distinction between those who are mentally stable and those who have difficulties, but rather bring about the awareness that mental health affects everyone, individually and collectively. People should not be discouraged to talk about feelings of neglect, shame, or humiliation because ignoring these difficult feelings often leads to a spiral of additional problems. Educational programs can provide those with difficult feelings the resources to deal with those feelings in a supportive and empowering way. In regards to psychosis, educational programs can destroy the misconception that psychosis is a rare biological syndrome. Further, educational programs can challenge the general public to rethink their understanding of psychosis, normality, and insanity. Understanding that those who experience psychosis have far fewer differences and far more similarities with those who do not experience psychosis, is an important first step in reintegrating those with psychosis back into the community.

Need for Revolution/Conclusion

This exploration into the construct of schizophrenia has been a transforming experience. A summary of research has shown that schizophrenia can not be simply understood as a biological disease expressed by certain behavioral symptoms. The categorization and simplification of psychotic experiences do not reflect the expansive and convoluted factors contributing to psychosis.

Part One of this paper concludes that the modern *making-up* of schizophrenia is based in little scientific validity. Further, the classification system along with the dependence on anti-psychotic drugs creates an environment that perpetuates suffering. Part Two explores criticisms of the psychiatric paradigm, which serves to reveal why the psychiatric paradigm is in a state of crisis that must be resolved. Finally, Part Three supplies progressive treatment methods that serve to empower rather than damage those suffering. Progress within the realm of psychosis depends on the empowerment and reconstruction of those suffering from psychosis. If the psychiatric domain wishes to progress, then it can start by acknowledging and transforming the areas in which it has failed.

Human beings are deeply embedded within the ubiquitous nature of suffering. Suffering constitutes a fundamental element of the human condition, which heavily influences the individual's course. One could imagine asserting, *I suffer therefore I am*. Humans are not the only organisms to experience suffering, but the complexities of human sociability and language certainly produces an emergent layer of mediation that suffering latches onto. Socially for example, suffering is now partly mediated through trauma or neglect. Human brains were not necessarily adapted to deal with suffering

stemming from the complexities of today's world. Further, the individual suffering or in pain is likely to be captivated by that source. Although suffering can never be completely eradicated, if people wish to ease the suffering of today's world, then solutions to causes and ramifications of suffering must be further investigated in both academia and the working-sector. However, any investigation into suffering requires the integration of those suffering rather than exclusion.

In regards to schizophrenia, it must be acknowledged that to label someone with a disease requires more evidence than purely behavioral symptoms. The medical field must realize that a history of over-diagnosis and misdiagnosis creates ramifications, which harm the individual's ability to recover. Through investigating schizophrenia, we see that the current state of America's mental health system reinforces assumptions that are damaging to suffering individuals. If receiving a diagnosis damages an individual's self-esteem and well-being, then the diagnostic system perpetuates suffering. Further, biological drugs are not the proper solution as they often create dependence and additional problems.

It is important to treat patients on a case-by-case basis because life experiences of the individual influence suffering and play a significant role in the road to recovery. Reducing psychosis to biology ignores how life experiences can often shape the psychosis. However, biological vulnerabilities and sensitivities matched with an overstimulated threat-affect system due to continued stress or trauma are likely to be the sources of many psychoses. In order for research and treatment methods to progress, psychiatrists must quit hastily diagnosing behaviors, focus on enhancing techniques to find the true source of suffering, and create a safe environment through compassion and

relationships to empower those suffering. Ultimately, if we wish to properly treat

psychosis, the psychiatric paradigm must be revolutionized to create structures that

empower those suffering on the achievable road to recovery.

Bibliography

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: APA

Aronson, E., Wilson, T., Akert, R. (2010) *Social Psychology*. New Jersey: Prentice Hall.

Arseneault, L., et al. (2011). Childhood trauma and children's emerging psychotic symptoms: a genetically sensitive longitudinal cohort study. *American Journal of Psychiatry*, 168, 65-72.

Bentall, R. (1990). *Reconstructing schizophrenia*. London: Routledge.

Bremner, J., et al. (2005) Positron emission tomographic imaging of neural correlates of a fear acquisition and extinction paradigm in women with childhood sexual abuse-related post-traumatic stress disorder. *Psychology Medical*, 35 (6), 791-806.

Carrion, V., et al. (2010) Reduced Hippocampal Activity in Youth with Posttraumatic Stress Symptoms: An fMRI Study. *Journal Pediatric Psychology*, 35 (5), 559-569.

Comstock, D., et al. (2008). Relational-Cultural Theory: A Framework for Bridging Relational, Multicultural, Social Justice Competencies. *American Counseling Association*, 86, 279-288.

Copeland, J., et al. (1971). Differences in usage of diagnostic labels amongst psychiatrists in the British Isles. *British Journal of Psychiatry,* 118: 629-40

Ellason, J. and Ross, C. (1995). Positive and negative symptoms in dissociative identity disorder and schizophrenia. *Journal of Nervous an Mental Disease*, 183, 263-41.

Foucault, M. (1965). *Madness and civilization; a history of insanity in the age of reason*. New York: Pantheon Books.

Freud, S. (1896). The Aetiology of Hysteria. *Stardard Edition*, 3, 203.

Freyd, J., et al. (2001). Self-Reported Memory for Abuse Depends Upon Victim-Perpetrator Relationship. *Journal of Trauma & Dissociation*, 2 (3), 5-15.

Freyd, J., Birrell, P. (2013). *Blind to Betrayal: Why we fool ourselves, we aren't being fooled*. Hoboken, N.J.: Wiley.

Gilbert, P. (2009). Introducing Compassion-focused Therapy. *Advances in Psychiatric Treatment*, 15 (3), 199-208.

Gobin, R. L., &Freyd, J. J. (2009). Betrayal and revictimization: Preliminary findings. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1, 242-257

Gomez, J. M. &Freyd, J. J. (2013). High Betrayal Childhood Sexual Abuse, Self Injury& Hallucinations. *121ˢᵗ Annual Convention of the American Psychological Association*, Honolulu, Hawaii.

Hacking, I. (1999). Making Up People. *The Science Studies Reader*. New York: Routledge, 161-171.

Harding, C., et al. (1987). The Vermont longitudinal study of person with severemental illness. *American Journal of Psychiatry*, 144, 718-26.

Hearing Voices Network. *About HVN*. Retrieved from htpp://www.hearing-voices.org/about-us/

Hearing Voices Network. *Voices and Visions*. Retrieved from htpp://www.hearing-voices.org/voices-visions/

Heine, S. (2012). *Cultural Psychology*. New York: W.W. Norton

Herman, J. (1992). *Trauma and Recovery*. New York: Basic Books.

Hunt,W., et al. (1953). Theoretical and practical analysis of the diagnostic process. In P. Hoch and J. Zubin (eds) *Current Problems of Psychiatric Diagnosis*. New York: Grune& Stratton.

International Society for Psychological and Social Approaches to Psychosis. (2005). *About ISPS-US*. Retrieved from http://www.isps-us.org/isps-us_mission.html

Kardiner, A. and Spiegal, H. (1947). *War, Stress, and Neurotic Illness*. New York: Hoeber.

Kendell, R. E. and Brockington, I.F. (1980). The identification of disease entities and the relationship between schizophrenic and affective psychoses. *British Journal of Psychiatry*. 137, 324-31

Kuhn, T. (1962). *The Structure of Scientific Revolutions*. Chicago: The University of Chicago Press.

Lamb, R. (1984). Deinstitutionalization and the Homeless Mentally Ill. *Hospital and Community Psychiatry*, 35 (9), 899-907.

Lardinois, M., et al. (2011). Childhood trauma and increased stress sensitivity in psychosis. *Acta Psychiatric Scandinavia*, 123 (1), 28-35.

Lataster T., et al. (2006). Childhood victimization and developmental expression of non-clinical delusional ideation and hallucinatory experiences: victimization and non-clinical psychotic experiences. *Social Psychiatry Psychiatric Epidemiology*, 41, 423-428.

Link, B., et al. (1989). A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment. *American Sociological Review*, 54 (3), 400-423.

Mayhew, S. & Gilbert, P. (2008) Comassionate mind training with people who hear malevolent voices. A case series report. *Clinical Psychology and Psychotherapy*, 15, 113-38.

Mckenzie, James F., Pinger, R., Kotecki, J. E. (2008) *An Introduction to Community Health*. Boston: Jones and Bartlett Publishers.

Mehta, S., & Farina, A. (1997). Is Being Sick Really Better? Effect of the Disease View of Mental Disorder on Stigma. Journal of Social and Clinical Psychology, 16 (4), 405-419.

Miller, J. B. (1976). *Toward a new psychology of women*. Boston: Beacon Press.

Mirowsky, J. (1990). Subjective boundaries and combinations in psychiatric diagnoses. *Journal of Mind and Behavior*, 11 (3-4), 407-423.

Morris, D. (1991). *The culture of pain*. Berkeley, California: University of California Press.

Page, S. (1977). Effects of mental illness label in attempts to obtain accommodation. *Canadian Journal of Behavioral Science*, 9 (2), 85-90.

Read, J., Mosher, L., Bentall, R. (2004). *Models of Madness psychological, social and biological approaches to schizophrenia*. Hove, East Sussex England: Brunner-Routledge.

Rosenhan, D. (1973). On Being Sane in Insane Places. *Science,* 179, 250-8.

Rosenhan, D. (1975). On Being Sane in Insane Places. *Science*, 179, 250-8.

Russell, D. (1984) *Sexual Exploitation: Rape, Child Sexual Abuse, and Sexual Harassment*. Beverley Hills, CA: Sage.

Scheff, T. (1966). *Being mentally ill: A sociological theory*. Chicago: Aldine Pub.

Schore, A. (2003). Early relational trauma, disorganized attachment, and the development of a predisposition to violence. *Healing Trauma: Attachment, Mind, Body, and Brain*. New York: W.W. Norton. 101-167.

Stuart, H. (2006). Mental Illness and Employment Discrimination. *Current Opinion in Psychiatry*, 19 (5), 522-526.

Thompson, A., et al. (2010) Psychotic symptoms with sexual content in the "ultra high risk" for psychotic population: frequency and association with sexual trauma. *Psychiatry Research*, 177, 84-91.

Unger, R. *Common misconceptions*. Retrieved from http://www.recoveryfromschizophrenia.org/cbt-for-psychosis-trauma-pychosis-handouts/

Unger, R. *Personal Steps toward a Revolution in Mental Health Care*. Retrieved from http://www.recoveryfromschizophrenia.org/about-ron-unger/personal-steps-toward-a-revolution-in-mental-health-care/

Watters, E. (2010). *Crazy like us: The globalization of the American psyche*. New York: Free Press.

Whitaker, R. (2002). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Cambridge, MA: Perseus Pub.

World Health Organization (1973). *The International Pilot Study of Schizophrenia*, Vol. 1. Geneva: WHO.

Wright, E., et al. (2000). Deinstitutionalization, Social Rejection, and the Self-Esteem of Former Mental Patients. *Journal of Health and Social Behavior*, 41, 68-90.