

9

Schizophrenia - Understanding the Illness

No other illness provokes so much controversy as schizophrenia. Its varied forms make it hard to understand, indeed, many people find it rather repulsive and scary. Physical illnesses are much easier to understand and deal with. The horrors of previous centuries, such as the plague, are now reduced to the status of common infectious fevers. Even lay people understand nowadays how physical illnesses come about and how they can be treated.

With schizophrenia it is different. The sick person's strange behaviour, the voices they hear, the fears they express, do not immediately point to a disorder of a physical organ. In spite of costly research we are still, faced here by many unsolved riddles. Schizophrenia was first identified as a separate illness at the turn of the century. The German psychiatrist Kraepelin talked about a »dementia praecox«, an premature dementia. Eugen Bleuler, medical director at the »Burghölzli« Psychiatric University Hospital in Zurich, was the first to describe and list the diverse symptoms of this peculiar disorder. His name for the illness was »*schizophrenia*« – the split mind.

The name was new, but not the illness. Schizophrenia is not confined to our age. Time and time again, history leaves us descriptions of people who manifested the typical disorders which we would label »schizophrenia« today. Equally, schizophrenia is not confined to particular geographical areas. It occurs in every land and nation, among all races and social classes. And it also occurs among believing Christians. Their fellow Christians often have difficulty understanding the changes which take place in those

who are affected. How is it possible for their thoughts, feelings and behaviour to be so deeply disturbed? How does it come that someone feels he is being followed by the secret service, or sleeps only on the floor, because he is afraid of radiation, and feels he is constantly guided by voices no other person can hear?

In recent years, schizophrenic people have become especially favourite patients of mine. It has been my privilege to walk with them and their relatives on their path through illness. Time and time again I have been amazed by their heroic struggle – both the struggle with their illness, and with the incomplete understanding by the world around them. I am writing this chapter for them, to moderate the injustice to which they are still continually subjected in modern society, inclined as it is towards success and normality.

Definitions and Statistics

Schizophrenia belongs to the group of illnesses known as psychoses. This term comprises severe disorders, which are recognisable by abnormal experience and behaviour as well as marked alteration of the personality, leading to the loss of the normal capacity for work. The person affected is no longer able to separate external events from their personal perceptions. Psychoses can last for a few hours or for years. They can be slight or lead to a complete breakdown of personality. Psychoses include:

- Organic psychoses (triggered by toxic substances, e.g. drugs or infections such as syphilis).
- Transitory psychotic reactions to stressful life events.
- The results of severe disturbances of the brain in old age.
- Manic depressive illnesses.
- Schizophrenia.

In this chapter I will deal with schizophrenia. The other disorders may be mentioned here and there, but not fully described. The interested reader should consult text books of psychiatry or the internet for further information.

Schizophrenia is a comparatively common disorder. About half the patients who require admission to psychiatric hospitals suffer from it. Two statistics will give an idea of its frequency.

Research has shown that about 0.4 per cent of the population suffer with symptoms of schizophrenia (acute or chronic) on any particular day. For comparison, about 15 to 20 per cent are depressive on any particular day, and about 12% suffer from symptoms of anxiety and personality disorders.

Schizophrenia affects 1 in 100 people in their lifetime. Every year, there are 6000 new cases in Britain alone. Schizophrenia has an irregular hereditary pattern. Table 9.1 shows the risk of suffering from schizophrenia when another member of the family is already afflicted.

Table 9.1: Hereditary risk of schizophrenia

Probability of inherited schizophrenia schizophrenic:	per cent
If one parent is schizophrenic	15%
If one brother or sister is schizophrenic:	10%
If both parents are schizophrenic:	20 – 40%
If an identical twin is schizophrenic:	50%
If a second degree relative (Uncle, nephew, cousin) is schizophrenic:	3 %

These figures may be disturbing, but if we look at them another way, it means that even if a mother who suffers with schizophrenia had seven children, statistically, only one would suffer with the same disorder. All the same, in such families we often observe an increased incidence of other psychological disorders, which point to an underlying disposition for psychiatric problems.

What allows the diagnosis of Schizophrenia?

Today the diagnosis of schizophrenia is made with careful (even reluctant) discernment. In the 1960s in America every kind of conspicuous behaviour and transitory psychosis was labelled as schizophrenia. But for two decades now strict criteria have been introduced for this diagnosis to be made. These are laid down in the DSM-IV, the Diagnostic and Statistical Manual of Psychiatric Disorders (4th revision). Yet even for experienced psychiatrists it is difficult to be accurate in borderline cases, particularly at the beginning of an illness. Often it is better just to speak of an »adolescent

Table 9.2: Diagnostic Criteria for Schizophrenia

DURATION: Total duration at least 6 months. Various durations are possible for the individual phases.

ONSET: Before the age of 45 years.

A. PRODROMAL PHASE

Obvious deterioration in comparison with earlier level of ability (performance at work, social relationships; care for personal appearance and hygiene). At least two of the symptoms listed below, which are not due to a disturbance in mood or to a psychoactive substance.

Symptoms During the Initial and Residual Phases:

1. Social isolation or withdrawal
2. Marked impairment of work, home life or studies
3. Marked peculiar behaviour (e.g. collecting rubbish, hoarding rotting food, uninhibited behaviour ...)
4. Marked neglect of hygiene and grooming
5. Apathetic, shallow or unconventional expression of feelings
6. Wandering, vague, over elaborate or circumstantial speech
7. Odd beliefs or magical thinking, influencing behaviour and inconsistent with cultural norms. Feeling of being influenced or being able to influence others, imagining significant connections between unrelated things or events.
8. Experience of abnormal perception, e.g. repeated illusions of the presence of an invisible person or power which cannot be experienced by others.

B. ACTIVE PHASE

At least one of the following characteristic features:

1. Bizarre delusions (essentially and obviously absurd and with no possible basis in reality.) For instance, feeling of being influenced or having special powers, or being able to read people's thoughts, or having thoughts extracted from your brain.
2. Delusions related to the body, delusions of greatness, religious, nihilistic or other delusions.
3. Delusions of jealousy or being pursued, combined with hallucinations.
4. Hearing voices (either commenting on the afflicted person's behaviour, or talking among themselves).
5. Distracted thought, marked tendency for mental connections to be seen much more loosely, marked illogicality of thought, and pronounced deterioration of verbal abilities, if this occurs together with at least one of the following features:
 - apathetic, shallow or unconventional expression of feelings
 - delusions or hallucinations
 - catatonic or otherwise severely disorganised behaviour.

C. RESIDUAL PHASE

(Residual = remaining). At least two of the symptoms listed under A, which continue after an active phase of the illness and are not caused by a bad mood or by drugs.

(adapted from the DSM-IV)

crisis« or simply a »psychotic condition«.

Three phases are distinguished in the course of a schizophrenic illness which are described more fully in table 9.2.

- | | |
|---------------------------|--------------------------------|
| A. Prodromal phase | (gradual deterioration) |
| B. Active phase | (acute symptoms) |
| C. Residual phase | (stable situation) |

Forms and Cause of Schizophrenia

It is not always easy to define individual symptoms of schizophrenia. Currently, the tendency is to distinguish three forms of schizophrenia which are briefly describable as follows:

1. HEBEPHRENIA (or disorganised schizophrenia)

Onset in younger years, childish, silly behaviour, breakdown of personality, often aimless, clearly reduced ability to work,

Example: 17-year old Sylvia from a well ordered family is experiencing various pressures. She is in the middle of the end of year exams, on top of which her friendship with a young man has just been broken off. Her personality changes increasingly. She becomes obsessed and pesters her ex boyfriend day and night with telephone calls. She feels sad, but laughs constantly and without reason. At work, she makes frequent mistakes. In the end she runs away and spends the night in the open air in the pouring rain. This leads to her being admitted to hospital.

2. CATATONIC SCHIZOPHRENIA:

Marked disturbances of movement are prominent over other typical symptoms of schizophrenia (e.g. remaining for hours in an unusual posture, or an agitated state).

Example: A 35-year old mechanic, Mr. Francis, is intensely occupied in building his own home. Tensions with the architect lead to a court case. Mr. Francis is unable to sleep, stops going to work, and spends all his time brooding over his building plans. One, morning his wife finds him sitting

at the table as if petrified. He constantly utters the words »watermain«, and knocks meaningfully on the table. The condition normalises with the help of medication after a three week stay in hospital.

3. PARANOID SCHIZOPHRENIA:

The patient suffers from a system of delusion which is beyond any real context (e.g. delusion of grandeur, delusion of being an inventor, delusion of being followed).

Example: 22-year old painter Thomas K. is convinced that four years ago he has discovered the laser beam. With the aid of a magnifying glass he has now developed a »computerised video magnifier« as well as a »photo driven helicopter«, which the police can use for tracking criminals. When he touches the table with his finger tips, he can store his feelings on the surface of the wood. He spends more than 5,000 Euros on tools and instruments to continue developing his inventions. He makes a lot of mistakes at work, because he continually feels distracted by murmuring voices and laser beams.

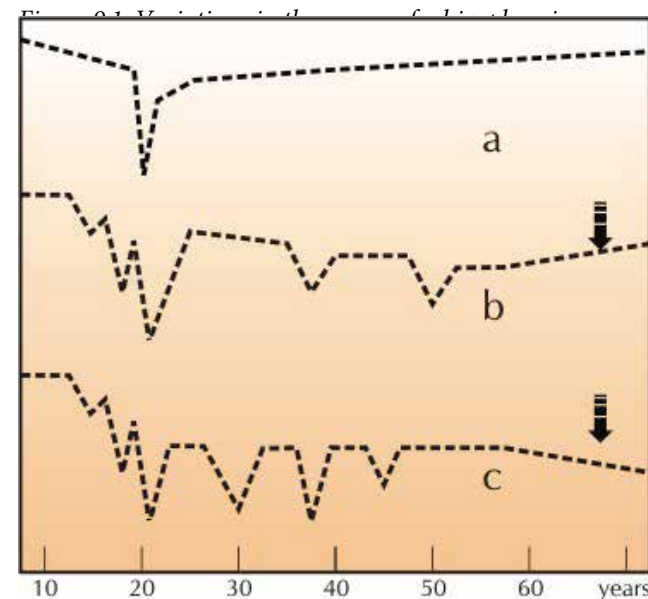
It is not always possible to categorise a condition under one of these forms of schizophrenia. In the hospital we observe the most diverse mixed forms for which there are yet other names. Two of these are named here: an insidiously developing schizophrenia with few symptoms will be labelled as »*schizophrenia simplex*«. If schizophrenic symptoms are combined with severe mood changes (severe depression or mania) we talk of a »*schizoaf-fective psychosis*«.

The Course of Schizophrenia

Research into the course of schizophrenia has shown that the prognosis for this illness is considerably better than has generally been thought.

There is no cause for unnecessary pessimism. Basically we can observe three possible courses for the development of schizophrenia, as outlined in Figure 9.1.

1. Single episode with no recurrence
2. Repeated episodes with resultant disability



3. Chronic deterioration leading to a severe residual state

1. In about 20 per cent of cases, an episode of schizophrenia does not lead to any further relapse, although these individuals experience heightened sensitivity under stress. Particularly favourable are the following features:

- normal adjustment before the illness.
- sudden onset with many symptoms.
- relatively good health after an episode
- harmonious conditions in the family / social system
- motivation towards regular treatment with medication.

2. In about 60 per cent of patients, further episodes occur over the years. During the intervals, these people live normal lives, even if in retrospect, they are less able to cope with stress. Unfortunately their ability is somewhat reduced after each episode. A so-called residual or defective condition remains, which makes it more difficult for them to operate effectively at home, at school, or in the workplace. It is not uncommon for them to have

to come to terms with a more modest goal in their career.

I think of Liz, a nurse who could only work to 70 per cent of her capability after a psychotic episode. After a further episode she was transferred to work at a convalescent home, where the demands made on her were less stringent. Every few years, when she was under unusual stress, she experienced a short crisis. Once it was an unfulfilled love. Another time an exhausting trip to Tunisia. She would feel better after a short stay in hospital. In her lovely, sympathetic way she was a great blessing to many patients.

3. Finally, about 20 per cent of patients develop a complete personality breakdown. Even under medication, they are not free from delusions and hallucinations. They are no longer able to work. Often they are incapable of caring for themselves and living on their own. Because of their bizarre behaviour and marked lack of personal hygiene and grooming they become such a burden for their relatives that they require continual supervision in a psychiatric hospital or another form of mental care.

The Psychosis as a »Jamming Station«

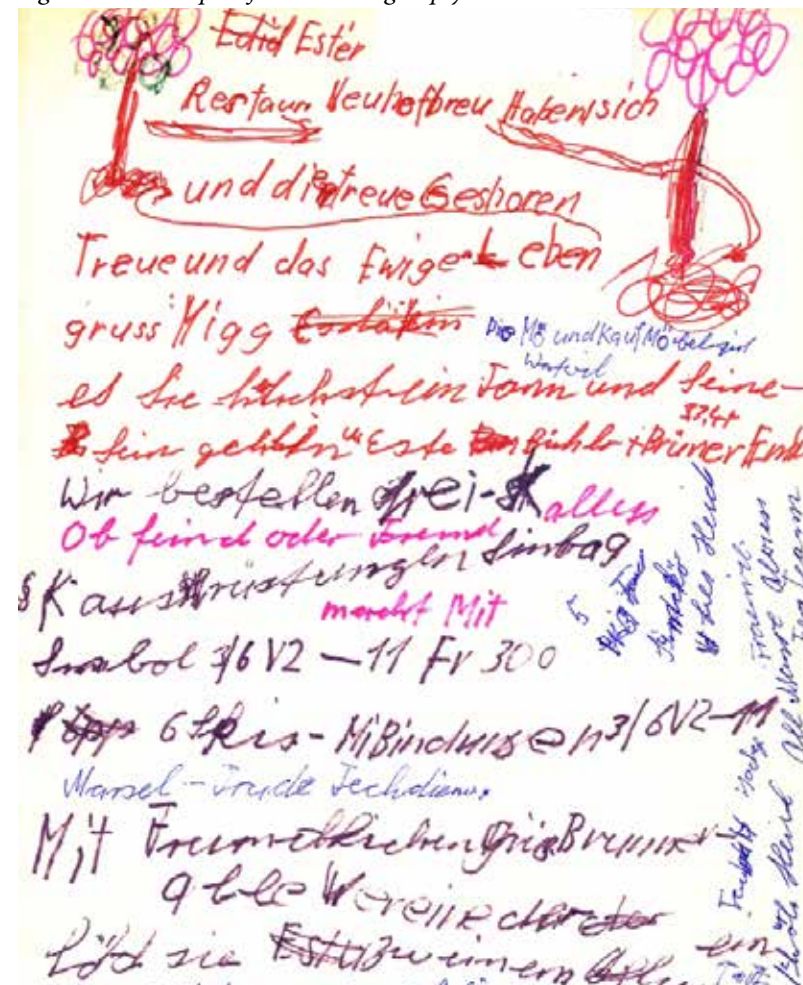
The research of the last few years has shown that at the roots of all forms of schizophrenia lie common disturbances which especially impair the thought processes of the brain. Additional difficulties, such as altered and suppressed expression of feeling, social withdrawal, alteration of self-awareness, delusions, hallucinations and motor disturbances, all follow from these disorders.

What do we mean by »thought disturbances«? Someone who has never experienced the mental changes in a person who is undergoing an episode of schizophrenia can hardly imagine it. I vividly remember a 28-year old woman, who developed a psychosis after having delivered a healthy baby. At her admission interview, communication was barely possible. Her thoughts were like a broken stained glass window. Word fragments sparkled out, but they didn't fit together, and no longer formed a picture for the person looking on.

»I feel like I am an N. N for necessity. But I can't get it, because there is an F in the way. I can't tell you what an F is just now. I don't feel myself any more. The dot in my »I« is missing. (She knocks her head pointedly to indicate the dot.) The word »marriage« has a special meaning, M for Marriage. If you turn the M upside down, there are three marks that look into the sky.

That's what I tripped over. Look at the R in marriage. I fell down the R. I fell down deep... a long, long way, until I came to the doctor. He gave me a tablet (the patient draws an R on the table, then an arrow underneath, and finally a circle to represent the tablet) and here I almost fell apart.«

This fragmentation of the thoughts is often underscored by a peculiar disturbance affecting handwriting. Figure 9.2 shows an example of the handwriting of a man during a psychotic episode, before he was treated with medication. Notice the uneven lines, the broken sentences, the desperate



rate attempt to make himself understood to the reader.

The affected patients are aware that they can't connect their thoughts any longer, especially when too many impressions crowd in at once. »My thoughts greet one another, but I don't know which one I should shake hands with«, is how one young woman expressed it. Often at the height of an episode patients will become so absorbed with what is going on in their mind, that they are unable to turn their attention to another person, let alone apply themselves to a job. They seem completely »gone out«. But you do these people an injustice to describe them as »insane«. They are just incapable, for a certain time, of processing the impressions that bombard them from within and without, in a normal way.

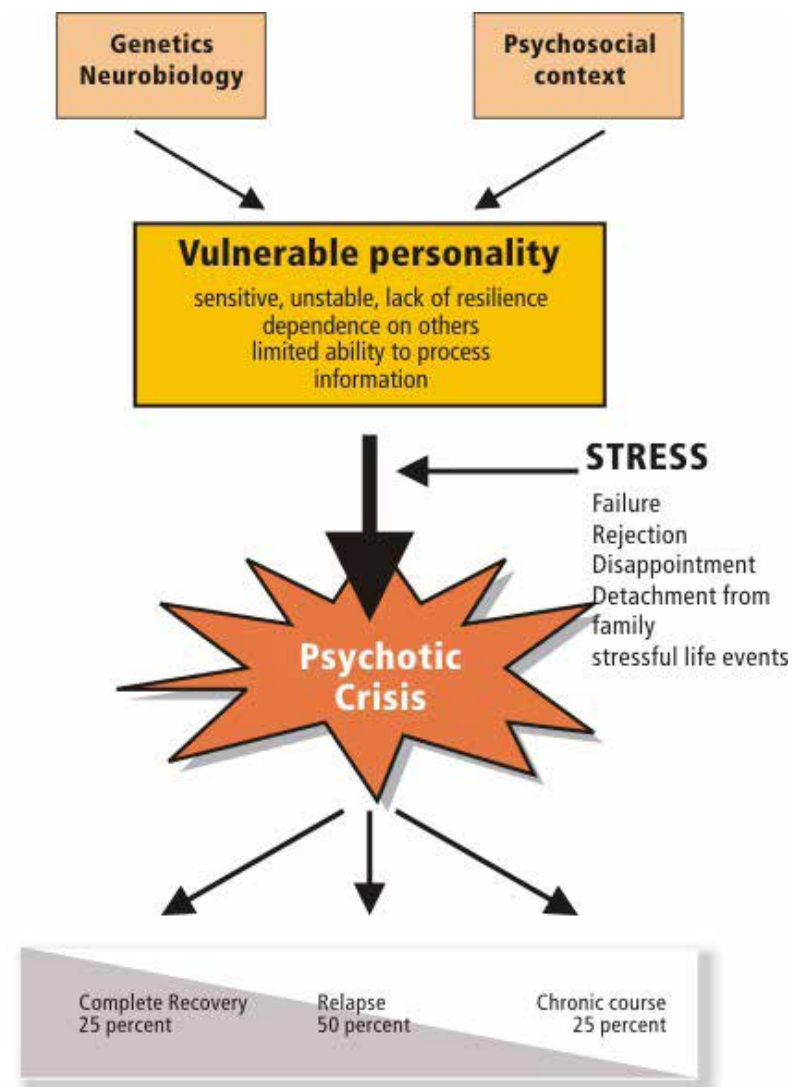
Yet, many aspects of their personality remain healthy. The healthy person is not lost, merely hidden behind the psychosis which takes the front stage. The psychosis often »jams the programme« so persistently that it can only be understood in a fragmentary way. It is precisely those who depend on the orderly processes of their mind for a career (e.g. teachers, engineers etc.), who suffer most when they can no longer make use of their ability. It is much more difficult for them to find suitable employment, than it is for a simple factory worker who remains capable of routine work after the acute phase has subsided.

How Does Schizophrenia Develop?

For decades now, researchers have been working on this question. Every year thousands of articles and books appear addressing this subject. Research is being carried out into many areas, from neurobiology to behavioural studies. The workings of our brain are so complex that so far we have only been able to propose models which may help us understand schizophrenia. Nevertheless, a number of main guidelines have been established, which can be supported by extensive research. The Swiss psychiatrist, Professor Ciompi has summarised these factors in a model (figure 9.3) which I will briefly describe as follows:

The *hereditary influence* can be regarded as established by the studies that have been made of twins and adoptive children. Schizophrenic patients obviously have an inherited weak point in the metabolism of the brain. The influence of the environment in turn chips away at this weakness. Over months and years they develop a *vulnerable personality* which is less able to cope under stress. This in turn can be recognised by the following cha-

Figure 9.3: A Model for the Understanding of Schizophrenia



adapted from Ciompi 1991

characteristics, among others:

- Impaired resilience and sensitivity
- Abnormal anxiousness
- Reduced ability to experience joy (anhedony)
- Reduced ability to express feelings
- Withdrawal into an inner world (introversion)
- Reduced self-reliance
- Difficulty in making and keeping up relationships
- Reduced performance at work or in school
- Limited capacity to process information.

When this vulnerable personality comes under pressure or stress, it ceases to be able to cope with the thoughts, feelings and responsibilities which arise, and a »nervous breakdown« occurs, a psychotic crisis such as has already been described. The triggers for this can be very diverse:

- failure (e.g. at school)
- rejection (e.g. by a person they love)
- disappointment (e.g. in attaining a career goal)
- excessive pressure (e.g. during a divorce)
- leaving the family to take up a new assignment or role (e.g. military service, the birth of a child)
- any other difficult experience (e.g. bereavement)

The relationship between vulnerability and stress can be presented in a simple diagram (see figure 4.2). Notice the distinction between *triggers* and *causes*. If a bridge collapses when a lorry passes over it, the weight of the lorry is only the final trigger for the bridge's collapse. The cause will lie in some weakness, perhaps the fact that for years the pillars of the bridge have been rusting without anyone noticing.

It is the same with the experiences which lead to the onset of schizophrenia, however stressful they may seem. The problem is not in the first instance with the experiences themselves, but with the way in which a person responds to those experiences. How many feelings of guilt, how many accusations, and how many empty clichés could be avoided by this way of viewing things! This is especially valid with regard to the religious triggers of schizophrenia, of which I shall speak later.

Schizophrenic Phenomena and their Explanations

How can we explain a person hearing voices which make negative comments or give her orders? How can we explain the situation of a young woman who refuses to eat because she is afraid of being poisoned? How is it possible for a man to become violent, just because his father asked how he is getting on? What causes a grown man to stop washing himself, never change his clothes and sleep every day until noon?

We have seen that medicine assumes that schizophrenia is basically a disturbance in the neurobiology of the brain. In chapter 3, I proposed a model of the brain as a computer. In so doing I was careful to make sure that this way of looking at it does not exclude pastoral concerns, but rather extended them, and particularly where schizophrenia is concerned, leads to a better understanding of the illness.

Let us briefly recall what is involved in the *information processing in the human brain*. First of all comes perception. We continually receive impressions through our sense organs (ears, eyes, etc.). In the brain's control centre this information is interpreted, sorted, and stored. We call this process *thought*. In connection with this we distinguish between the *content* of thought, and thinking as a *process*. The sentences you are reading here are part of the »content« of this book. However, what you do with them, how you take up the information and hold it in your memory, would come under the heading of the thinking process.

Now let us turn to our schizophrenic patients whose control centres so to speak have been disturbed. Their thought process is no longer capable of correctly interpreting, valuing, sorting and storing the information which keeps pouring in. Perceptions are distorted and linked with inappropriate feelings retrieved from the memory. Hallucinations are the result. The contents of the memory are called back to the conscious mind (on to the projector screen) without the voluntary command of the control centre, and then combined with other things. For example the sick person may suddenly hear his own thoughts, but in the tones of his sister's voice.

Experiences and ideas, fears and desires, are called out of the memory store without obvious reason and thrown together as if in a gigantic jigsaw puzzle. For near relatives the individual ideas and words still, more or less, make sense. They know the experiences of their sick relative and can still draw together threads from the bizarre comments but the outsider is a stranger in this world. During a schizophrenic episode, the divisions

between real experiences and the inner world becomes permeable. Fantasy and reality are melted together into a chaotic system of delusion. The afflicted person tries in vain to drag his surroundings out of the deceptive world of his madness and into reality, but again and again waves of psychosis break over him.

It is no wonder that this also leads to reactions in the patient which can be difficult to understand. He is no longer in a position to apply his faculties and his behaviour to a concrete situation. Once I waved to a patient in a friendly way. But he ducked as if I had thrown a stone at him. He had noticed my movement, but interpreted it wrongly, and linked it with feelings of fear and threat. For him, his reaction was logical, but from my point of view it was bizarre.

So now we understand better how schizophrenic symptoms come into being. But in Christian circles there are further questions to ask: What is the explanation of religious mania? How should schizophrenic symptoms be categorised from a spiritual perspective? I will deal with these questions in the next chapter.

References Chapter 9: Schizophrenia

Torrey E.F.: *Surviving Schizophrenia: A Manual for Families, Consumers, and Providers*. Perennial Currents.

Foster M.: *Schizophrenia Revealed: From Neurons to Social Interactions*. W.W. Norton.

Woolis R.: *When Someone You Love Has a Mental Illness: A Handbook for Family, Friends, and Caregivers*. J.P. Tarcher

A wealth of information can be found in the internet

10 Schizophrenia and Christian Faith

Doctor, I'm in terrible trouble,« an elderly lady complained to me. »Tonight I should have gone to heaven, but my room mate stopped me. God allowed her to torment me, and now I can't forgive her any more. Do you know, two years ago, I committed a terrible sin. The doctor wanted to take my blood, but I wouldn't let him. I didn't realise at the time that I should have made a great sacrifice. It's because I didn't give my blood that God hasn't taken me to be with him yet.«

What sense would you make of a story like that? How would you advise the woman? Would you teach her about the once for all true sacrifice that opens the way to God? Would you encourage her to forgive? Or try to help her see that she was imagining it all?

These are the kind of questions which will face a pastoral counsellor who is dealing with schizophrenic people during a delusional phase. It is not uncommon to meet sick people who use a Christian vocabulary and thus have what in the broadest sense of the word could be termed as »religious mania«. This observation throws up a host of questions for Christians as well as non-believers.

Often, false conclusions are drawn from the use of religious terms. Even among physicians and other members of the caring professions one can hear the widespread opinion that a person's psychosis has been caused by religious involvement. At very least, the impression is given that »religious mania« is a negative outcome of religion's impact on society.

These assertions are based on prejudice, rather than on careful scientific research. I will look into a few studies on the theme of religious mania

in a later section, but first of all I will explain how religious delusions develop, and how they can be understood.

Explaining Religious Delusions

Basically, three forms of religious delusion can be distinguished:

- a) Religious images used to explain schizophrenic experiences
- b) Delusive distortions of genuine religious faith
- c) Mistaken interpretation of religious terms and unusual beliefs on the part of the therapist.

The first two are to be regarded as characteristic ways in which schizophrenic people make sense of their experience. The third form of religious delusion derives from the prejudice and lack of understanding of a therapist who is faced with expressions of religious faith with which he is not familiar.

a) Religious images used to explain schizophrenic experience.

To those affected by them, the experiences involved in a schizophrenic mental disorder seem very eerie, »supernatural«, strange and menacing. They are plagued by ideas and fears which they cannot explain in terms of their previous frames of reference. They feel as if they have abilities and a calling which is more than normal, yet they also notice the destructive influence of the illness on their work, their relationships and eventually, their own personality.

How can a person like this make sense of the experiences which break over him during a psychosis? Often earthbound images are no longer sufficient for this task. However, in religious teaching he has heard about angels and demons, prophetic messages and signs and wonders. In this way even people who are not normally influenced by Christian faith develop the most fantastic religious delusions. When the schizophrenic episode subsides, their faith also returns to its previous level.

b) Delusive distortions of genuine religious faith.

The patient has a healthy faith before his or her illness. Nevertheless like other aspects of life, this comes to be experienced and expressed in a

distorted way. I am reminded of a young woman, a believer, who suddenly felt a need to be »on fire for the Lord«, in contrast to her earlier behaviour. She became motivated more and more by thoughts about »the lost«. She reached a point where she could hardly sleep, and she gave out piles of tracts. One day, out of the blue she injured her wrist with a knife. She explained to her shocked parents that she had shed her blood for the lost because it was Good Friday. Under treatment, the disturbance subsided in the course of a few days, and her spiritual life suffered no harm as a result. Today the young woman is married and an active member of her church.

Depressive delusions, which can take on grotesque forms, such as thoughts of having committed terrible sins, also belong to this category. In this connection, please refer to the chapter on Depression in this book.

c) Unusual expressions of faith

Unusual expressions of faith are sometimes misunderstood by professionals as an expression of the illness in schizophrenic patients, in spite of the fact that these may express the actual beliefs and practices of his church or religious group.

At this point a great deal of understanding of unusual forms of Christian thought is necessary to avoid doing the patient an injustice. If a Bible College student expresses the desire to »tell everyone about Jesus«, it doesn't necessarily mean he is suffering from a »missionary mania«, even if he is also suffering from a schizophrenic disorder. He has simply been trained to pass on the gospel to other people, just as the Bible teaches.

It becomes more difficult, when a German lady explains that she has been »delivered from a Hitler demon«. In order to be able to decide whether this is a delusion or just a strange teaching, you need to know that this was said by a certain »pastoral counsellor« who in a routine way persuaded many other mentally healthy fellow believers of German origin that in order to grow spiritually they needed deliverance from a »Hitler spirit«. (This happened in Switzerland in 1985).

Granted, teachings like this strain the understanding of the most tolerant psychiatrist, and they make it easier to understand why people who work in the field of psychiatry are often prejudiced against believers. It is especially important here to distinguish between belief, superstition and delusion. Nevertheless, a Christian has the right to be taken just as seriously in a psychiatric hospital as an environmental campaigner, or a psychotic peace activist, whose opinions may be closer to those of the staff.

Does Christianity Make You Ill?

This question can be clearly answered in the negative in regard to schizophrenia. Over the last 30 years there has been quite some research in the field underlining that religion has primarily a stabilizing effect. Two research projects in Swiss psychiatric hospitals have specifically dealt with the interrelatedness of psychosis and religion. They both demonstrated that no connection can be established between religious upbringing and religious mania. One author comes to the conclusion: »In this way the surprising result of our study indicates that a strong religious interest in the parental home is more often linked with a weak religious element in the psychotic theme than with a strong one.«

Generally it is true to say that religious delusion is only one of several themes of insanity. One should never conclude from the *content* of the delusion that the *cause* of the schizophrenic illness is to be found within it. This would be just as absurd as holding technology responsible for the onset of a schizophrenia in which the patient felt himself influenced by lasers and computers, or blaming environmentalists for the development of a »ecological mania«.

What does influence the theme of delusions? Much evidence points to the probability that the dominant ideas and world view of a culture in turn influence the content of the delusions which occur. Krantz, a German psychiatrist, researched the contents of patients' delusions in 1886, 1916, and 1946, and could demonstrate how the discovery of new technologies (e.g. radio) or equally the rise of the Führer, coloured the delusive ideas of the mentally ill. More recent studies have established that over the decade a change has taken place in the frequency of particular themes of delusion.

Delusive ideas are often formed by the experiences and activities which for the patient are bound up with strong feelings (fear, love, failure or rejection). In our age, where life is no longer shaped so much by faith in God, we also find fewer religious delusions. In contrast, in recent years, against a background of dying forests, chemical accidents and nuclear catastrophes, a delusive environmental fear has clearly taken hold.

To sum up, it can be said that a delusion may have a religious slant to it, but no conclusion can be drawn from this about the cause of the illness. The development of a delusion can be better understood by reference to a sick person's life situation and personality structure, but never completely explained by it.

Schizophrenia in the Literature on Pastoral Care

Having offered some explanations of schizophrenic symptoms from a scientific viewpoint, I would like to briefly examine one or two theories found in Christian books. Anyone who thumbs through the available literature on the subject of pastoral care will find three main approaches:

- a) Recognition of schizophrenia as a sickness, with no particular pastoral point of view.
- b) Emphasising sin and irresponsibility.
- c) Emphasising a demonic cause (»occult bondage«).

It is necessary to comment briefly on these models, in order to shed light on an area which causes many Christians insecurity, and extra difficulty with their sick relatives. From what I have said already it will be clear that schizophrenia is to be viewed as an illness which requires medical treatment. However, establishing that schizophrenia is an illness does not exclude the need for pastoral care. Concepts must therefore be developed which enable us to counsel and care for the needs of fellow Christians with schizophrenia.

Schizophrenia and Sin

Jay Adams' school of pastoral counselling emphasised the role of sin and personal responsibility. Psychosis was seen as an avoidance of confrontation with biblical truths and a flight from responsible living. For instance, if a young man became psychotic after a failure at school, this was seen as a way to avoid facing the fact of his failure and the responsibility of disciplined work.

I would not wish to question Adams' basic intention to bring biblical truth back into pastoral care. Unfortunately his writings show an outdated and one-sided reading of the nature of schizophrenia, even at the points where he still admits the possibility of an »organic« cause. Although the sinfulness of human beings is the cause of many difficulties, this concept cannot be applied in a simplistic way to the complex phenomenon of schizophrenia.

It can be very misleading to link two statements with the word »*because*«. Consider the following sentence: »Car accidents occur because cars pollute the environment.« Both statements are absolutely true, but the link

made between them isn't. All cars pollute the atmosphere, but in only a tiny per centage of cases does the pollution become the cause of an accident. In addition to this, we know that there are many other contributory causes for accidents, besides pollution of the environment. Now consider the following fact: All human beings sin, but only one per cent become ill with schizophrenia. Are we then to blame the afflicted person's sin for his illness, without looking for other causes?

Schizophrenic people are capable of sin, as we all are. It may seem banal, but they can also be forgiven, as we all can. In less severe situations in particular, schizophrenic people enter an intermediary phase where they can be accountable in a normal way. In chronic cases, much of the patient's behaviour is affected by the sickness and not caused by any evil intent. So I have to ask: Is it sin, if a chronic schizophrenic continues, even after many warnings, to clomp around at night in clogs and never wash himself? In my opinion, no, although I agree that such behaviour is disturbing, perhaps so much that it would no longer be possible to keep the patient at home because those who live with him can no longer cope with his unrest.

Schizophrenia and the Occult

A few writers of books on pastoral care suggest a causal connection between schizophrenia and demonic influence. The following quotations are all taken from the same book:

First, the author asserts »all the descriptions of psychosis which we find in the Bible show the characteristics of guilt and occult bondage.« From this basis he argues that all psychoses in our time are connected in the same ways. To the question, »Why are not more Christians aware of this?« he replies, »So the chief reason for this mistaken understanding of the psychoses would seem to lie in the fact that the sensitisation of the spirit, which is needed for the demonic powers to manifest and become active, was clearly never, or only seldom successful.«

There are still more problems of explanation. How can a person who has never allowed themselves to become involved in occult practices still become prey to a psychotic condition? The answer: »The occult problem of a psychotic person never has its beginning in his own lifetime. I was always able to trace a line of demonic oppression back for at least two and usually three to four generations.«

This has consequences for treatment. Deliverance ministry will be necessary, but unfortunately, usually unsuccessful. The explanation: »Deli-

verance ministry to a psychotic Christian is tiring, and usually time consuming. If the foundation of faith needed for active progress in deliverance has not been laid in the pastoral counsellors and the church, it is better to send the sick person to the hospital for medical treatment. The time for a spiritual offensive will come later.«

So now the church is to blame for the fact that the psychotic person hasn't improved. The patient is finally shoved into the hospital where »worldly« people can look after him until he has recovered enough for the pastoral counsellor who specialises in deliverance ministry to plague him with the next spiritual offensive. I would like to leave the reader to judge whether such an approach is helpful, compassionate, or even biblical.

So does occult activity not play any role in schizophrenic people? Here the same applies as with the question of sin and schizophrenia. Schizophrenia can also be mixed up with occult involvement. But confession and deliverance ministry do not bring release of the whole problem. It is a great injustice therefore to believers who are experiencing a crisis, to brand them as »demonised« and subject them to stressful exorcism rituals. Exorcisms in this situation often lead to a worsening of the psychosis.

So far I have not been able to recognise any improvement in the external situation and spiritual life, let alone the basic illness of patients, resulting from models of pastoral care which refer to sin or occult bondage as the primary cause. Much more frequently the relatives' and patients' trust in the pastoral counsellor is destroyed to such an extent that any co-operation between the psychiatrist and the pastoral counsellor is rendered impossible.

So, how can we deal with schizophrenic people in a pastoral context? Are there alternative approaches? Can psychiatric and pastoral help be integrated? What possibilities lie open for biblical pastoral care of schizophrenic people? These are the questions we shall address in the next chapter.

References Chapter 10: Schizophrenia and Faith

Specific literature references concerning religious delusions can be obtained from the author. E-mail: pfeifer@sonnenhalde.ch.

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11 Schizophrenia – Therapy and Pastoral Care

The treatment of schizophrenia has changed dramatically in the last fifty years. When I look through the case notes of my patients I am always moved by the terrible impasse in which schizophrenic patients found themselves prior to 1950. There was hardly any means to ease their restless anxiety and delusive ideas. Doctors and medical staff grasped at doubtful straws in the attempt to make life more bearable for these patients who frequently would become so absorbed in their psychotic inner world, that conversation from outside no longer reached them. The thought of a return to their family was out of the question.

Even mild schizophrenic episodes which nowadays subside in a matter of weeks used to last months or years without medication. Hannah Green gives a striking picture of this period in her book »I never promised you a rose garden«. Today the time when patients were calmed down by being wrapped in wet sheets or sat in covered hip baths is long since past.

In our time most patients with schizophrenia live outside the hospital. Their care is the responsibility not only of psychiatrists and caring professionals, but of pastoral counsellors and the relatives who live with them. In the following pages I will show some possible approaches to the care of schizophrenic patients, which take account of medical and social as well as pastoral aspects. The best possible care can only be achieved when all work together for the best of our patients.

Three Pillars in the Treatment of Schizophrenia

The multitude of different approaches to the treatment of schizophrenia can be divided into three main groups:

1. Medication (with neuroleptic drugs)
2. An ordered daily routine
3. An emotional climate conducive to improvement.

1. Medication

Since disturbances in the neurobiology of the brain play an important role in schizophrenia, medication has a fundamental influence on the condition. Neuroleptic drugs are the medication of choice (such as Halidol, Risperidone or Zyprexa, to name a few). They generally lead to a calming and ordering of the thought processes. Continued medication under the supervision of a doctor is the most important pillar in the prevention of a relapse.

Unfortunately, not all problems can be solved even by the regular intake of medication. To be honest, severe and insidious forms of schizophrenia are only affected to an unsatisfactory extent. Nevertheless, if the schizophrenic patient is only rendered a little calmer, it can make it easier for relatives to take care of him at home, instead of having to have him treated at the hospital.

Neuroleptic drugs, like all drugs have side effects. Muscle cramps, drowsiness, and restlessness in the legs are the most common in the »first generation neuroleptics« (e.g. Halidol). However, these can be controlled by additional medication in the majority of cases. The newer drugs often cause major weight problems (e.g. Zyprexa). As a general rule of thumb, the drugs are given in the correct dosage if the acute symptoms are under control and normal sleep patterns are maintained.

2. Daily Structure

Patients with schizophrenia frequently find it difficult to order their day. For this reason, modern psychiatric practice will be to encourage a program of occupational therapy during the week, whether in the hospital or outside in a sheltered workshop. They need protection from stress on the one hand, but training for their remaining abilities as well as contact with other people on the other. A regular daily routine is important for the following reasons:

- a) A clear timetabled programme helps the patient to be orientated and breaks up the monotony of a long day.
- b) It communicates to the patient the sense that he is needed and can do something useful.
- c) It provides a break for relatives and spreads the burden of care so that it rests on more shoulders.

3. Emotional Climate

People who suffer from schizophrenia are generally less able to cope with pressure than others. The reaction of their environment, especially that of their relatives, can contribute to the prevention of a relapse. It is necessary to accept the patient with his limitations, without taking all responsibility away from him.

That is not always easy. A few years ago now, researchers thought they had established that the reaction of relatives was an important factor in coping with the illness. »E.E. research« (expressed emotions) confirmed that the relatives of patients who made a good recovery accepted them better, criticised them less and gave them more independence. The conclusion was drawn from this observation that patients recovered well because their relatives behaved in this way. However, it is becoming increasingly clear today that the opposite was the case. The relatives found it easier to behave in this way because the patient was improving so well. Nevertheless the relatives and carers need continual encouragement to show the sick person love in the right way, and to set appropriate boundaries.

A Word about the Psychotherapy of Schizophrenia

In support of the three pillars mentioned above, supportive conversations and sympathetic advice can be very valuable for the patient. Particularly in times of crisis, they are grateful for the support of a professional person who can help them overcome the problems they face.

However, psychotherapy in the strict sense has not proved valuable with schizophrenic patients. For most schizophrenic individuals psychotherapy is an excessive burden, indeed it can cause a great deal of damage. Attempts to release feelings, and to work through hidden motives are particularly dangerous. I have observed several relapses and even suicides which have been triggered by psychodynamic group therapies, transactional analysis, primal scream therapy and similar approaches.

At this point it needs to be said that intensive approaches to pastoral

care can have the same results. Treatment of schizophrenia belongs properly in the hands of the psychiatrist, supported by sympathetic carers, pastoral counsellors included, who know their limitations. What contribution can be made to the therapy of schizophrenia patients by biblically orientated pastoral care?

Pastoral Care for the Schizophrenic Person

Counselling depends on the ability of a person to take part in a conversation, on his ability to understand, properly interpret and apply the things that are said. However, when it comes to people suffering from schizophrenia – particularly during an active phase – the severe illness-related disturbance to their thought processes means that there are severe limits to what can be achieved through counselling sessions.

The conversational ability of schizophrenic people can be differentiated in accordance with the various phases through which the illness passes. A patient is least capable of receiving benefit from counselling during an acute psychotic episode. In the times between episodes normal conversation is often possible. The same applies to the spiritual life. This is severely disrupted by the disturbed thought processes but can nevertheless become completely normal again, and when it returns, it can be an important support for the patient.

In view of this I would like to deal with the possibilities and limitations in the pastoral care of schizophrenic people in two sections, namely

- a) in the acute phase and
- b) during the residual phase (including the residual intermediate phase).

How to Respond to Acute Symptoms

1. Keep calm and try to keep bringing the person back all the time to the level of reality, in other words, talk to them about the real situation, even when they find it hard to receive what you are saying. The circumstances under which admission to a hospital becomes necessary, can be very dramatic. As a result the pastoral helper can easily get left out of the picture at this point.
2. Be logical and do everything to motivate the sick person to receive medical treatment. These sick people basically need to be cared for by a medical specialist. Only rarely can someone with an acute episode of

schizophrenia be successfully treated as an outpatient. As a rule these people have no insight into their illness. For this reason in certain circumstances it is necessary for this decision to be taken out of the hands of the sick person. If you have to do this you should not show any sign of personal uncertainty. Since these patients have been disorientated, as counsellors we have to give them clear direction.

3. Behave in a natural and unobtrusive way. Don't put on a kind of protective patronising manner, but behave in a friendly way to the sick person, talking as naturally as possible with them.
4. Visit the sick person during their stay in hospital so that they doesn't lose contact with the normal world. It is important, in this connection, that during his hospital stay the sick person is prepared for the time after discharge. It will be important both during the stay in hospital, and even more so afterwards, to talk in an encouraging way about God's love and the love of the people at church, and to stress God's ability to carry him through.

One word of caution is needed, however: Visits should be arranged, to begin with, in careful consultation with the medical staff. For a sick person whose psychological condition is weakened, visits can be very stressful and lead to a further worsening of his condition.

Pastoral Care on the Return From Hospital

Medical treatment does not render careful pastoral support unnecessary. On the contrary, the very thing a believer needs when he or she has gone through the distressing experience of a psychosis, is to understand and work through the illness in the light of their faith. What questions will they be likely to bring to the pastoral counsellor? In the consultations I have had, the questions I have encountered fall into three groups:

1. Questions of meaning and of faith
2. Questions about the illness: its causes, prognosis, medication, etc.
3. Questions about coping with life:
 - a) Coping with reduced ability to endure stress
 - b) Practical arrangements for living
 - c) Advice and comfort for relatives

Questions of Meaning and Faith

The experience of a psychosis raises questions for the believing patient and his relatives, which they are not usually able to voice to the psychiatrist. Here are a few examples:

- Why has God let this happen?
- Where does the illness come from? Is there sin or occult bondage involved?
- We have tried everything. Why isn't prayer working?
- Why is the spiritual life so disturbed?
- (Dora, a 23-year old clerk): »I don't have any assurance of faith any more! It seems as if my neighbour has stolen it. She's always looking at me with a dark expression on her face.«
- (Richard, 32, a former teacher): »I'm often so tired that I can't make sense of the Bible any more. I just lie around all the time. Can God really still help me?«
- and finally: »Is there still hope?«

You will notice that there is no simple answer to any of these questions. We often have to struggle with the suffering of the schizophrenic patient in much the same way as with that of the cancer victim. In this phase pastoral care needs to be characterised by compassion and patience. Not in a resignative kind of waiting, but actively »helping the weak« in the knowledge and certainty of God's Word. Christians have a hope which reaches beyond such things as health, the ability to work, or riches and happiness!

There is no need to pay too much attention to religious delusions, because in most cases they will fade away of their own accord. The best thing you can do is to hold the patient to the biblical facts in simple words, full of conviction. For example, you could respond to Dora's question in this way: »Maybe sometimes you're not able to hold on to your faith the way you used to. But Jesus is faithful. He is stronger than all the powers of darkness. He holds us even when we don't have the strength to hold on to Him any more. You will get your joy back again. It just needs time for you to get better.«

Richard used to be a teacher, who has already been unfit for work for eight years (residual state). He needs continual reassurance that his value to God does not depend on his career. For him the promise is especially relevant which says »The Spirit of God comes to our aid. We are weak and do not know how we should pray. For this reason the Spirit approaches

God on our behalf with groans which cannot be expressed in words«.

The answers in these situations are similar to those in the care of people who suffer from severe physical disabilities. I have continually experienced how patients in the weakness of a residual schizophrenic state learn to trust God and draw strength from His Word. Of course, it goes without saying that pastoral counselling should not stand in isolation from practical support and advice for the patient and his relatives.

Questions About The Illness

As schizophrenia is so difficult to understand, the pastoral counsellor, no less than medical personnel, will be confronted with questions about the illness, and will need to be in a position to give well-informed answers. If you have read this book carefully, you will be able to answer the most important questions about the causes, understanding, and course of schizophrenia.

Often the sufferer will also want to hear what the pastoral counsellor thinks about the medication. »Do I still have to take tablets?« they may ask, »I don't want to become an addict!« Under no circumstances should someone seeking advice be encouraged to stop taking neuroleptic drugs. Always direct them towards their doctor and explain to them how helpful medication can be, even when it means putting up with a few side effects.

It is better to be able to live, work and attend church outside the hospital, than to slip into a psychosis without tablets or injections. Regular use of neuroleptic drugs should not be compared with an addiction. A better comparison is with the regular administration of insulin to a diabetic, who also suffers, of course, from a disturbance of the body's metabolism. As a general rule, the ability to regularly get sufficient sleep is a good sign that the time may be right for a reduction of the medication. If you notice that a schizophrenic person is suddenly sleeping less and is more strongly driven, get in touch with their doctor.

Compassion and Patience

Relatives often need to talk as well. How often they find themselves in the dilemma of asking »To what extent is the patient's behaviour caused by the illness, and to what extent is it intentional? How should we respond? And at what point does it become necessary to admit the afflicted person to hospital again?« Even experts are not always able to answer these ques-

tions. Often it is not, in the first instance, a matter of right and wrong, but more a question of how much the carers can cope with in a particular situation.

Pastoral counsellors who care for schizophrenic people need a great deal of patience and a willingness to carry the burdens of sick people and their families, without seeing spectacular changes. Nevertheless, this does not imply that there is any reason to lose hope. Do not forget that, with correct treatment, 75 per cent of all cases improve, though it takes considerable time. Those who share these burdens should be encouraged by the promise, »so will you fulfil the law of Christ!« It isn't enough to give them admonitions from the Bible. If you really want to help people who have a chronic psychiatric illness, you will need to discover afresh the meaning of comforting and supportive pastoral care.

Rehabilitation: Support or Burden?

Often well-meaning pastoral counsellors (not to mention behaviourally orientated social workers and psychologists) tend to overstretch the patient and his family. I once asked a doctor who was a committed Christian, »What is your goal in the treatment of schizophrenic patients?« I was dismayed by his answer: »For them to be as healthy as I am!«

Why was I dismayed? Is this request unreasonable? Certainly, the wish is good, but the effect of it can be that you expect too much from the patient, and hence from yourself. In the long term, the result is always disappointment, for the patient as much as the helper.

Schizophrenic patients who already have gone through several episodes and show an obvious reduction in their general performance are less capable of handling pressure, even in their »good« times. The personality of a chronic schizophrenic patient is sometimes described as »silted up«. That is a good way to describe these emotionally flattened people who are incapable of handling pressure and have little self initiative. Such people can be activated to a pronounced degree through the kind of committed care that can be provided in residential homes and communities.

Nevertheless, it is essential to recognise the boundary between encouragement, and making excessive demands. It is certainly possible to train these patients to a certain degree and spur them on to a higher performance, but in the process they are often placed under an uncomfortable pressure to succeed, a tension which can lead to a further relapse. Without constant supervision they do not have the power within them to apply

independently what they have learned before. They are like crumbling sandstone, which cannot be returned to its former shape.

Therapists who do not recognise these boundaries remind me of children, who apply themselves to build a sandcastle with enthusiasm and effort, but almost as soon as their work is left to the wind and the waves the signs of decay begin to show. The beautiful towers and carefully excavated gateways are washed away.

This is why we need to ask »Where are the limits of what can be attained in our chronically ill patients? And which is of more value: A person who lives within their limits and is content with them, or a chronically overtaxed patient who can only maintain his level through the constant efforts of a number of carers?« If attempts at rehabilitation have shown that a patient is pushing his limitations, we have to accept these and help him to make the best of them. It can no longer be the carer's job to groom him to be a star performer in a competitive society. We are not called to build impressive sandcastles, but to lovingly create a context in which the fragile sandstructures of the chronic schizophrenic person can survive. To protect them, care for them and carry them, in the full knowledge of their weakness.