The Schizophrenic's Social World
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Ball State University
Muncie, IN
April 25, 1996

Graduation date: May 4, 1996
Purpose of Thesis

The following discussion of the social experiences of people afflicted with schizophrenia is based on related psychological research studies. While people with schizophrenia obviously experience a wide range of problems in life, the focus here is limited to social problems. This discussion of the social deficiencies of schizophrenics considers three points: (1) The relationship between schizophrenia and crime, including a discussion of which subgroups of schizophrenics might be more prone to committing crime, (2) less serious social deficits associated with schizophrenia, such as anxiety toward interpersonal interactions, and (3) therapy aimed at alleviating those less serious social deficits.
Psychologists usually study behavior within one of the many subareas of psychology. For example, cognitive psychologists study memory, while physiological psychologists study the nervous system. Perhaps some of the most intriguing research in psychology, however, is that which brings multiple subdisciplines together to study a problem. One example of this process is the interface between abnormal and social psychology. Abnormal psychologists study disordered behavior, while social psychologists study the behavior of people in groups. The study of how people with disorders behave in a group setting, then, would involve each discipline. One disorder of particular interest to abnormal psychologists is schizophrenia. The Diagnostic and Statistical Manual (DSM-4) describes schizophrenia as being characterized by disturbances in thinking, mood, and behavior. Misinterpretation of reality, delusions, and hallucinations are common. Behavior is typically withdrawn or regressive; for example, patients usually do not keep up maintenance behaviors such as bathing. Social psychologists also have been interested in schizophrenic patients. Social research has focused on a variety of issues, including criminal behavior committed by schizophrenics. Research in this area has focused on whether schizophrenics are at an increased risk of committing crimes, the characteristics of patients who are more likely to commit violent rather than non-violent crimes, and the
question of why schizophrenics might display this form of deviant behavior. Outside the realm of criminal behavior, social psychologists have looked at the social deficits that non-criminal schizophrenics experience, and have suggested therapeutic measures that might aid in overcoming those deficits.

Schizophrenia and Crime

Prevalence

Researchers have found that schizophrenics are more likely to commit crime than members of the general population. Wessely, Castle, Douglas, and Taylor (1992) sought to show that a patient with schizophrenia would be at an increased risk of acquiring a criminal conviction, and would show an increase in his or her rate of convictions compared to non-schizophrenics. The researchers collected cases for the study from the London Borough of Camberwell and took steps to ensure that those patients who had been inappropriately labeled but did have schizophrenia would not be left out. These steps included looking over case files of non-schizophrenics and determining whether the researchers agreed with the diagnosis given. The cases selected for analysis covered a twenty year period to ensure control for age and time period. Detailed clinical records and conviction records were analyzed for each case. Schizophrenic men did not show increased risk of criminality in general.
(i.e., all crimes including non-violent) compared to men with other mental disorders. However, the risk of male schizophrenics being convicted for a violent crime was found to be at least twice as high as that of men with other disorders. Women, on the other hand, had an increased rate of conviction across several offense categories. Unfortunately, the researchers reported only ratios in their results, not actual conviction rates. The actual rates might give a better idea of whether these differences are really significant. The researchers pointed out the limiting fact that the study consisted solely of detected criminal behavior. This is problematic because some criminals are neither caught nor convicted.

Lindqvist and Allebeck (1990) followed schizophrenic patients who were discharged from a Stockholm mental hospital. The study involved 790 patients born between 1920 and 1959 diagnosed with schizophrenia at the Stockholm county hospital. Conviction records were obtained for this sample. The benefit of this study was that the police kept records of individuals who were not convicted for crimes due to factors such as age or mental abnormalities. The researchers also looked at a comparison sample of the same size which consisted of non-schizophrenics. Results indicated that schizophrenics were four times more likely to commit violent crimes than “normal” individuals. That is, 45 schizophrenics in
the study committed 164 crimes, 43 of which were violent. “Normals,” on the other hand, committed only eleven violent crimes (122 non-violent crimes). While the risk for schizophrenic men did not seem to be higher than the risk for non-schizophrenic men, the results did show that females had a doubled incidence rate of crime (seventeen crimes compared to seven in the non-schizophrenic population).

**Predicting Who Will be Violent**

Whether the link discovered between schizophrenia and crime can lead to predictions about which schizophrenic patients might go on to commit violent crime still remains in debate. Since 1950, research findings have been consistent in illustrating that schizophrenics have been more frequently involved in crime than the general population (e.g., Glancy & Regehr, 1992). Lindqvist and Allebeck (1990) pointed out that although the rate of violent offenses does seem higher among schizophrenics, research in that area is incomplete. They suggested that high-risk patients should be retained in a mental-health setting to avoid future misconduct, but low-risk patients should be allowed to live on their own whenever possible. Although some research has suggested ways to differentiate low and high risk (e.g., Klassen & O'Conner, 1988), Lindqvist and Allebeck felt that research was insufficient at the time of their study.
It does seem clear, however, that people afflicted with different subtypes of schizophrenia are prone to committing different types of crime. Glancy and Regehr (1992), for example, found that minor property crimes (e.g., shoplifting, loitering) might be committed by schizophrenics who are turned onto the streets without the proper resources to survive in society, such as a job or a home. Other research has shown that violent crimes against people are more likely to be committed by paranoid schizophrenics than by chronic schizophrenics (e.g., Addad, Benezech, & Bourgeois, 1981). Delusions, one symptom of paranoid schizophrenia, have been correlated with violent offenses (Hafner & Boker, 1973). McNeil (1994) also noted that schizophrenic patients can commit homicide for unpredictable reasons when hallucinating. Taylor (1993) studied violent behavior in prison inmates and found that only 9 of 121 men with a psychotic illness were considered to be free of symptoms at the time their crime was committed. In other words, most criminals with a psychotic illness were experiencing the symptoms of their illness at the time they committed an offense.

Although subtype of schizophrenia seems to be an important variable, gender seems to be another factor involved in predicting which group of schizophrenics might commit violent crime. The violent crime
rate among female schizophrenics as reported by Lindqvist et al (1990) was twice that of the general female population.

In addition to the factors listed so far, Klassen and O'Conner (1988) listed a variety of other factors that could be involved in determining which patients are at high risk for committing future crimes. Their study looked at 304 adult males admitted as inpatients at a mental health facility. In addition to interviewing their subjects, they examined health records, arrest records, and admission records. The technique used by these researchers was found to be over 90% accurate in assessing non-violence, and over 80% accurate in assessing violence. The researchers indicated that the following factors had the highest correlation with future acts of violence: occurrence of a violent incident in the past year ($r = .35$), mental retardation ($r = .30$), whether assault was involved in their most recent crime ($r = .24$), whether the patient's current job had been held for more than one year ($r = -.21$), whether the patient's age was less than 25 ($r = .20$), and a feeling of being let down by the family ($r = .20$). While these correlations are not very high, they may account for some cases, especially when large populations are considered. The researchers cautioned that a clinician should look at these factors only when primary factors, such as thoughts of harming others or delusions ordering harm of others, were present.
Explanations for Criminal Behavior Among Schizophrenics

Discovering why some schizophrenics are prone to violence while others are not could aid in removing violence-prone individuals from society or in helping to remedy the factors at fault. It would also be interesting, however, to understand what social-psychological processes underlie schizophrenia. Researchers have not explored these ideas, but some hypotheses might merit future study. For example, one possibility is that schizophrenics are, for whatever reason, unable to be socialized into behaviors that mainstream culture considers acceptable. Normal socialization involves modeling and vicarious learning. Average children observe what parents and peers do and copy that behavior if it is rewarded, or avoid that behavior if it is punished. Perhaps children who later develop schizophrenia cannot make this distinction.

Similarly, it is possible that schizophrenics do not benefit from operant learning. In operant learning, a child will repeat a rewarded behavior and will shy away from a punished behavior. Because schizophrenics are more likely to be repeat offenders than normal individuals, it is possible that they do not make a mental link between their punishment and the crime that preceded it.

Another idea related to the idea of socialization is conformity. Research has shown that schizophrenics tend to commit violent acts while
experiencing delusions or hallucinations. These delusions frequently involve hearing voices, and the voices generally tell the individual to do something. It is possible that the schizophrenic patient merely obeys the voices without thought of consequence.

It is important to understand why schizophrenics, or any other category of violent offenders, act differently from other people. Discovering the social causes of schizophrenic crime may lead to prevention. While research has focused on precursor variables such as previous crime and age or gender, it is still important to look at what causes these variables to lead to violence.

Other Social Deficits and Treatment

Clearly the most serious social deficit that might be associated with schizophrenia is criminal behavior. It is clear, however, that only a small number of schizophrenic people have crime problems, so one may wonder how the rest of the population afflicted with this disorder relates to their social world. Even non-criminal schizophrenics experience great difficulty interacting with others.

Proximity and Intimate Self-Disclosure

Gelburd and Anker (1968) found that the presence of a stranger, especially in close proximity, is aversive for schizophrenic persons. Ninety-one male schizophrenics were randomly assigned to seven groups.
Two independent variables were manipulated: the proximity of human contact the patient had while completing a task, and when during task performance that contact occurred. Subjects were given a series of five worksheets in which they were to cross out the a's in a list of printed letters. There was a rest period after each worksheet was completed. There were three levels of proximity: (1) there was no one present (no contact); (2) the experimenter sat about four feet from the subject (moderate contact); and (3) the experimenter sat right next to the subject facing him (intense contact). The time during which contact occurred varied four ways: (1) the experimenter was with the subject during the task and rest periods; (2) the experimenter was present during the task period, but not during the rest period; (3) the experimenter was absent during the task period, and present during the rest period; and (4) the experimenter was absent during both rest and task periods.

The experimenters measured the difference between the time it took to finish the first and last worksheets, expecting to find that subjects in the intense group and the group that experienced contact during task but not rest periods would show the biggest decrease in time. This was hypothesized because these subjects would realize that they had to finish quickly to be alone again during the rest period. Subjects in the intense contact group with the experimenter present during rest but absent during
task time, on the other hand, would likely show the largest increase in time, because they would want to delay the presence of the experimenter as much as possible.

These hypotheses were supported by the results of the experiment. It seemed that any subject who could minimize experimenter contact by increasing their speed on the task would do so, and any subject who needed to decrease their speed on the task to minimize contact would do that.

While these results are telling, the generalizeability of this study is limited because only one experimenter who had no prior contact with the patients was used, and the experimental process took place on only one occasion. Questions arise such as: Would contact with a person known by the patient produce different results? What characteristics of the interaction are important?

The results of a second study help to answer some of these questions. Smith and Cantrell (1988) looked at nurse-patient interactions at a Veterans Medical Center. Subjects in the study were male schizophrenic inpatients between ages 18 and 50. At the heart of the study was the interview scenario. The subject would sit with the nurse in a room and the two would talk. There were two independent variables of interest: Distance and conversation content. The distance variable had
two levels, intimate (sitting with chairs together, knees touching) and social (sitting with the chairs three feet apart). The conversation content variable had two levels, as well. Personal conversation consisted of the nurse asking personal questions of the subject, whereas impersonal conversation consisted of the nurse asking general questions (e.g. about the hospital). The subjects were randomly assigned into one of these four groups. After the interview, the subjects completed the State-Trait Anxiety Inventory (STAI) as a dependent measure of anxiety, and a pulse rate was taken (these measures were also taken before the study to serve as covariates).

Results indicated that pulse rates were higher in the scenarios where personal questions were asked, regardless of distance from the nurse. Close physical proximity seemed to have a larger adverse effect on the patient's anxiety level when combined with a verbal invasion of space than when combined with general conversation. These results are obviously relevant to care-givers in hospitals and other settings as they seem to indicate that close physical distance alone may not be as distressing as once thought to schizophrenic patients. A more personal level of conversation, on the other hand, does seem to intimidate the schizophrenic patient.
Shimkunas (1972) found similar results using a slightly different research procedure. In this study, the experimenter talked about an experience in one of two ways: either as a personal experience, using thoughts and feelings, or as an experience that could happen to anyone, in a very impersonal manner. The subjects' responses were rated by the experimenter, using a recording of the conversation, on five dimensions: personal disclosure (from absence of involvement to an intimate, expressive response), avoidance (from direct focus to refusal to comment), suspiciousness (from complete trust questioning of the experimenters intent), delusional thinking (from lack of delusions to constant reference to plots to do him in), and autism (from lack of illogical thinking to bizarre and illogical associations).

The experimenter first told the subject (both schizophrenic patients and non-schizophrenic controls) that he was going to tell them some information about a topic, and when he was through, he wanted them to express their opinions on that topic in the same manner the experimenter had. He then proceeded with either the personal or impersonal version of his talk.

Results indicated that the schizophrenic patients avoided interpersonal interaction, especially when that interaction was intense (i.e., very personal or intimate). Schizophrenic subjects showed a great
deal more autistic characteristics than control subjects. Paranoid schizophrenics also showed much more delusional behavior than their non-schizophrenic counterparts.

The results of these studies clear up some questions about how schizophrenics deal with others. First, it would seem that the content of the discussion is more likely to produce anxiety than the distance between the patient and another person. Second, it seems that personal conversation is anxiety-producing whether the conversational partner is a stranger or someone known to the patient.

**Decentering Levels**

Another way to gauge how schizophrenics view their social world is by use of the Thematic Apperception Test (TAT). Strober (1979) studied the difference between schizophrenics' and non-schizophrenics' level of decentering on the stories told while looking at a TAT picture. Decentering, according to Strober, involves the content of the story told. The lowest decentering score would indicate that the subject did not differentiate between the people in the picture. No relationship is discussed, and little specific information is given. A mid-range decentering score would indicate that the subject did interpret some relationship between the people in the picture, and that the subject indicated that some specific event was taking place between them. The
highest decentering score would indicate that the subject discussed feelings and emotions related to the situation in the picture.

Strober asked both schizophrenic and non-schizophrenic patients to tell a story related to a TAT picture. Each subject was shown three pictures (the same three were used for each subject) over a two week period. Results indicated that schizophrenics showed significantly lower levels of decentering on each TAT card, as well as lower levels of decentering when all scores were averaged.

If the stories told by the schizophrenic patients are indicative of the way in which they view their social world, an interesting picture emerges. It seems that schizophrenics do not see a deeper meaning within the social content of their lives. They see people and actions, but not interactions or emotions. This theory could help explain why these patients feel anxiety when confronted with interactions that include emotion or very personal content. If those types of interactions are unfamiliar to them, it seems logical that anxiety would arise in those situations.

**Therapy**

Clinical psychologists frequently study techniques designed to improve the social interactions of schizophrenics. Techniques most commonly found to be effective are those which include modeling and
role-playing. Positive outcomes are a common finding; practitioners are able to improve a wide array of behaviors that may increase the quality of life for the patient.

Gutride, Goldstein, and Hunter (1973) found a technique to enhance overt social interactions was a combination of modeling, role playing, and social reinforcement therapy. Eisler, Hersen, and Miller (1973) had discovered the therapeutic value of modeling in assertiveness training with different subgroups of psychotic patients, but Gutride et al believed that modeling combined with role-play and reinforcement could have an additive effect on the patient's response. An experimental group of schizophrenic patients participated in a four-week learning therapy program. A control group was told that they were going to be receiving a new type of therapy, but that the program had to be delayed for a few weeks. All participants completed test materials before treatment to assess baseline conditions. For the experimental group, the therapy consisted first of a modeling segment. Participants were divided into groups of five to eight individuals. They watched four videotapes showing how an individual can interact with another individual, how he can initiate that interaction, how interaction might be initiated with a group, and finally how one could resume social relationships outside the hospital. During the showing of these tapes, a group leader drew attention to the
behavior of the model. After the video, the patients discussed the circumstances portrayed in the video, and how it related to their own lives. Next, the patients role-played interactions depicted by the model, as well as interactions suggested by the group leader, but not modeled. As the role-play behavior became closer to that of the model in the video, social reinforcement was used by the group leader and, frequently, other group members as well.

Post-testing was conducted by having the patient sit in a waiting room to see the psychiatrist. Another “patient,” actually a confederate, would rate the participant’s social interactions. The confederate would ask certain questions at specified intervals, either regarding the actual therapy program (for experimental subjects), or regarding expectations of the upcoming program (for control subjects). Participants’ responses were rated by the confederate on a scale from eye contact made to response given to initiates conversation, et cetera. The same types of observation were made in naturalistic settings; for example the researchers would observe the patients interacting with each other.

Results revealed that this type of learning therapy was effective on both acute and chronic schizophrenic patients. Significant differences between the experimental and control groups were found on all observation measures. However, no long-term follow-up on the patients
was conducted, so it is impossible to say whether the effect was short-lived or long-lasting.

Another study emphasized the importance of four elements in any therapy program designed to train interpersonal skills: situations relevant to the patient, both spontaneous as well as role-play situations, a person other than the therapist to make an assessment after treatment of whether the patient had improved, and the inclusion of both trained and untrained situations in the post-treatment observation (Finch & Wallace, 1973). The researchers compared role-play situations with spontaneous situations because they believed that the role-play cue may act as a signal for patients to act in a certain way, which would not be the case for spontaneous behavior.

This study trained a group of male schizophrenics on the interpersonal interactions that caused them the most anxiety (determined by self-report). In addition to role-playing situations in small groups, the patients were also given homework assignments to work on in dyads. Patients were encouraged to provide feedback for those doing the role-playing; for example, "I can't hear you" when the patient was speaking too quietly. They were also encouraged to stay focused and not drift to other topics. The therapist was initially the one to point out when a subject
was drifting during role-play, but the other patients in the group eventually learned that responsibility as well.

At the end of treatment, an outside researcher who was unaware of which patients had received treatment observed both trained and untrained behavior, and rated the behavior for factors such as loudness and fluency of speech, eye-contact, and latency of reply to questioning. The experimental group did show improvement compared to a no-treatment control group. In fact, after treatment, five of the eight experimental group members were discharged, compared to only one of the control group members. Follow-up indicated that four of the six discharged (all from the experimental group) were able to go on to work and contribute to their communities.

The experimenters attributed the success of their program to the fact that patients were trained to focus attention, perform basic social skills (such as eye contact), and that patients were encouraged to give feedback to each other, possibly reinforcing their own good behavior.

An obvious shortcoming in each of these studies is the likelihood of a placebo effect. The control group participated in no similar type of therapeutic activity while the experimental group participated in therapy. Therefore, it is possible that the experimental patients could have reacted to the attention of the researchers, rather than to the treatment alone.
While it does seem clear that the treatment had a positive effect for the patients, it would be interesting to know how much of that effect resulted from the treatment, and how much resulted from exposure to the therapist. A study that included a similar time commitment and type of activity for the control group, but still had these significant results, would be far more convincing.

Overall, the results from studies on therapy to improve the social skills of schizophrenics are promising. Still, it seems clear that training can only improve the patient to a certain degree: Few schizophrenic patients ever recover to their pre-morbid level of functioning. Also, the training is more likely to be beneficial for milder cases than for severe ones, such as criminal schizophrenics. Criminal schizophrenics obviously demonstrate a more severe deficit than could be improved by this type of skills training. Research is still needed to determine whether criminal schizophrenics' might ever become capable of living on their own without fear of criminal activity. Obviously, social skills training would be near the end of treatment for these individuals. First, some attempt would have to be made to make them understand concepts such as law, crime, punishment and the like. Due to the serious nature of the disorder, it seems unlikely that therapy alone could achieve that goal.
Schizophrenia is a disorder that permeates every aspect of a person's existence. Intellectual functioning declines, basic maintenance functions decline, occupational functioning declines, and hallucinations and delusions make daily existence miserable. In addition to these already horrible facts of life, these people cannot participate in social life to any degree of normalcy. It seems that they cannot feel comfortable when faced with intimate conversation. They do not seem to understand that relationships exist between people, and that people express and sympathize with emotions. It seems tragic that a group of people who would have so much to gain from rich social interactions, such as much needed sympathy and friendship, do not seem to desire or understand those social concepts.
References


