**The Social Construction of Schizophrenia**

**SOC195 Sociology of Disability**

**Introduction**

Even though the term “schizophrenia” was not officially coined until just one century ago, schizophrenia is one of the world’s oldest documented disorders. Instances of schizophrenia are recorded as far back in time as Ancient Greece and Rome, though the people living at those times did not know how to explain or classify this disorder. Over time, schizophrenia, a “split from reality” was given the name it has today. It is now defined by many doctors and psychologists including Kearney & Trull in their latest edition of *Abnormal Psychology and Life: A Dimensional Approach* as a psychotic disorder that frequently involves the experience of hallucinations, delusions, social isolation, and bizarre behaviors that often render the diagnosed individual unable to carry out many aspects of their ordinary life, thus almost completely disabling them (Kearny & Trull, 2012, pg. 347-353).

Schizophrenia in society has a rich history, and the face of the disorder is still developing. Schizophrenia started out as an undiagnosed mental illness and gradually developed into the disorder we know today. It played a role in both American and German Eugenics, experienced frequent mass institutionalization during the Renaissance as well as WWII, and then mass deinstitutionalization in the 1950’s (Friedlander, 1995). Today, schizophrenia has a stable place in society where professionals and people diagnosed with the disorder are working to deconstruct the stigma that its rocky past has brought upon it. Scholarly studies get closer and closer to determining accurate demographics of the disorder, and psychologists and psychiatrists discover more effective methods of treatment (Mortensen et al, 1999).

**What is Schizophrenia & how is it a Disability?**

Kearny & Trull define schizophrenia as “a psychotic disorder marked by positive symptoms such as delusions and hallucinations, and negative symptoms such as flat affect and withdrawal, and disorganized behavior.” PubMed Health (2010) adds to this definition by providing matching symptomology including psychosis, delusions, hallucinations, disorganized thought processes, difficulty sleeping and concentrating, bizarre behaviors, social isolation, and loose associations (thoughts that skip quickly from one to the next). These may seem to be a vague or broad range of symptoms for the same disorder, but it appears this way because schizophrenia manifests differently in everyone. Nemade & Dombeck, both doctors and major contributors to *Mental Help Net*, an online source of hundreds of articles on various aspects of mental health and disorders, add that these symptoms, though most of them are mental rather than physical, are involuntary and manifest without the ability of the diagnosed person to control them. Many symptoms, such as memory deficit, reaction time, and problem solving, in fact show neurochemical differences in the brains of those with schizophrenia when compared to those without schizophrenia, suggesting that the disorder may be the result of a neurochemical imbalance or structural abnormality in the brain (Nemade & Dombeck, Evidence that Schizophrenia is a Brain Disease).

The World Health Organization (2011) states that a disability is “an umbrella statement, covering impairments, activity limitations, and participation restrictions.” Nemade and Dombeck elaborate the given symptoms of schizophrenia in what fits the definition of a disability. For instance, when people are experiencing psychosis, it is certainly a form of mental impairment that does not allow them to function as cognitively normal people would. Delusions and hallucinations restrict the activity of schizophrenic people in that they often mentally believe things that are not true and are irritable and anxious to the point that their participation in many simple activities is limited (Nemade & Dombeck, Disability and Schizophrenia).

Kearney & Trull discuss the case of a 29-year-old man named James, who is unable to participate fully in his work and is often overwhelmed with apprehension because he has intense fear that he or important people, from family members and friends to the president, will be harmed. James’s disorder disrupts his life, renders him unable to work, and puts strain on his relationships. His paranoia, frequent delusions, and unusual behavior led to in-patient treatment at a hospital after a particularly difficult episode of paranoid apprehension, and James was immediately diagnosed as schizophrenic. In these ways and many others, schizophrenia acts as a disability that hinders people in their everyday lives (Kearney & Trull, pg. 346).

**Instances of Schizophrenia in History**

Although the term “schizophrenia” did not officially exist until Eugen Bleuler coined it just one century ago, in 1908 (Fusar-Poli & Politi, 2008, pg 1407), it is one of the oldest documented mental disorders. Psychologists had begun attempting to give a name and classification to the disorder decades ago. Adityanjee et al put together a comprehensive literature review of the history of the word “schizophrenia,” tracing its roots back to Phillippe Pinel, a French physician who advocated for better treatment of patients in institutions, particularly mental asylums. Pinel named the disorder “demenc**é,**” which means “loss of the mind,” in 1801. Wilhelm Griesinger, a German neurologist and psychiatrist, called the same illness “demensia paralytica” in 1845, as his neurological background led him to believe that symptoms were caused by structural abnormalities in the brain. In 1852, French physician and psychiatrist Augustin Morel used the term “demencé precocé (premature dementia) todescribe a case of schizophrenia in one of his younger patients (Adityanjee et al, 1999, pg 438-440). After studying what were at the time modern ideas of dementia and mental deterioration, Emil Kraepelin grouped delusions, hallucinations, catatonia, paranoia, and other unusual behaviors into the one disorder called “dementia praecox” in 1899, thus setting the basic foundations for schizophrenia as it is known today (Barham, 1984, pp. 15-16). It was not until 1908, however, that the term “schizophrenia” was officially drawn on by Eugen Blueler, a Swiss psychiatrist (Fusar-Poli & Politi, pg 1407). Blueler’s definition of schizophrenia differed from those before him in that he noticed a difference and presence of both positive (physical) and negative (mental) symptoms of schizophrenia in people suffering from the disorders (Adityanjee, pg. 440). He proposed the term “schizophrenia” be used to describe people with this mental disorder rather than “dementia praecox” because it emphasized a splitting of the mind, one of the most prevalent symptoms of schizophrenia, rather than dementia, which was becoming to be recognized as a different disorder entirely (Fusar-Poli & Politi, pg. 1407).

Though we can pinpoint when in history schizophrenia became a recognized mental disorder, Clark’s *Mental Illness in Perspective: History of Schools and Thought* (1973)describes instances of schizophrenia, though it was then an unknown disorder, recorded in history that date at least as far back as 460 BCE. The Ancient Greek poet Sophocles wrote the tragedy of “Ajax,” a character that Clark believes shows many symptoms of schizophrenia. Ajax suffers from chronic delusions and hallucinations, and believes that he is killing fellow solider Odysseus out of jealousy over a set of armor, when he is in fact killing a flock of sheep. William Harris, PhD at Middlebury College, adds that Ajax’s inability to cope with the decisions of others, such as the decision of Greek leaders to give Odysseus’ armor to Odysseus instead of Ajax, could very well be what led to the “splitting” of Ajax’s mind and caused his psychotic break. The armor was something of great honor and value to Ajax, and in his mind it was wrongfully given to Odysseus. Ajax saw the solution as killing Odysseus and gaining rightful control of the armor. However, hallucinations led him to kill a flock of sheep instead (Harris, chapter 11 in “Euhemerism”). Delusion and confusion such as this are some of the most visible symptoms of schizophrenia (Kearney & Trull, pg. 348), and when seen in literature as old as 460 BCE, one suspects that it had a place in ancient times, even if the term “schizophrenia” was not yet recognized as a word.

Clark also points out scenarios written in the Bible that hint at the prevalence of modern diagnosed mental illnesses. In the “Book of Daniel*,”* King Nebuchadnezzar of Babylon was said to have delusions and hallucinations causing him to believe that he was turning into an ox, which today would be a definite sign of schizophrenia in an individual. Indeed, “he was driven from men, and did eat grass as oxen, and his body was wet with the dew of heaven…(Clark, pg. 17). This description of delusion, hallucination, and abnormal behavior is one of the clearest yet, and certainly manifests as a type of mental disorder, with symptoms pointing to schizophrenia. These two monographs harbor so many examples of documented schizophrenia symptomology in different places and at different times that it is clear that schizophrenia as a mental disorder has been present in humankind long before it was given a proper name, possibly since the beginning of man.

**Institutionalization & Deinstitutionalization of Schizophrenia**

Institutionalization and deinstitutionalization of schizophrenia has occurred continuously for centuries, even before schizophrenia was a known mental disorder and people with all different types of mental illness were classified as “feebleminded” or “insane” and lumped together into one group of mental patients. Until about the 1600’s, most people with mental disorders lived with family at home, as this constituted the pre-institution era of the United States (Nemade & Dombeck, Institutionalization and Deinstitutionalization)

However, as towns grew bigger in the 17th century, the burden of the homeless, criminal, prostitutes, and mentally ill on society became more pronounced. Nemade & Dombeck (Institutionalization and Deinstitutionalization) as well as Clark (pg. 29) emphasize that this led to the first major wave of institutionalization of mentally ill people, including those with schizophrenia, as all types of people with mental disorders were still classified as one, and anyone who was thought to be a burden to society, no matter their mental state, was institutionalized. As quoted by Stanley (1998) in Snyder & Mitchell,

“The beggar was the most conspicuous figure of dependency, and in [nineteenth century] opinion, the most loathsome-a suspect figure who allegedly thrived on deception rather than work, who got something for nothing… (Snyder & Mitchell, 2006, pg. 40).

The number of people institutionalized at this time for the convenience of getting them off the street and benefitting society is so great that Foucault called it “The Great Confinement (Clark, pg. 29).” Large institutions began to open up to hold the criminal, prostitutes, vagrant, and mentally ill – no matter what illness the person had. Kearney & Trull agree that one of the main goals of institutions at this time was to remove people with mental disorders and other undesirable traits such as vagrancy from society, since they could not care for themselves and would likely become burdens (pg. 11-12). One of Philippe Pinel’s biggest problems with La Bicetre upon his arrival at the institution was that “the mentally ill were thrown together with every other type of socially maladjusted person imaginable, such as beggars, prostitutes, and criminals (Mackler & Bernstein, 1966, pg. 716)”. Because of this, institutions were staffed by few people and keeping patients out of society rather than rehabilitating them was the main goal (Kearney & Trull, pp. 11-12).

One of the most famous institutions, founded in 1547, was the Bethlehem Royal Hospital, or “Bedlam,” as many called it (Clark, pg. 29). Bedlam was specifically a psychiatric hospital but held horrific standards of care for patients. Conditions were poor, and electroshock therapy, insulin coma, and lobotomies were commonly used as methods of “treatment (Nemade & Dombeck, Institutionalization & Deinstitutionalization).” Today, these procedures would never be used as forms of treatment, as they are dangerous and the remission rate of symptoms after treatment was very high. J. L. Crammer describes a later outburst of insulin coma therapy for schizophrenia and mental disorders in the early 19th century as “a medical craze, a sudden enthusiasm without scientific basis enduring for 25 years and then collapsing (Crammer, 2000, pg 332),” and today we know that it has no merit as a treatment for schizophrenia.

In the 1700’s Bedlam began allowing people to observe the patients for entertainment (Clark 29), a cruel and immoral act that can be seen in William Hogarth’s recognizable series of paintings, *A Rake’s Progress*. *A Rake’s Progress*, published in 1735, tells the story of Tom Rakewell, who wastes the money passed down to him after his father’s death in London on luxury, gambling, and prostitution, and is eventually thrown into The Bethlehem Royal Hospital a vagrant driving himself to madness. In Hogarth’s depiction of Bedlam in Panel 8 of the series, two upper class women are seen standing among the poor, mentally ill, and prostitutes, observing them for the sake of their own leisure (Sir John Soane’s Museum, 2011).

In the late 1700’s and early 1800’s the Reform Movement began, bettering the quality of institutions and the treatment for patients. Two major leaders of the Reform Movement were Philippe Pinel (1745-1826) and Dorothea Dix (1802-1887). Kearney & Trull describe the changes that Pinel made when he was put in charge of La Bicêtre, a mental hospital in Paris, in 1793 (pg. 12). He allowed patients to exercise and have access to the grounds, as well as required larger, single rooms, advocated treating patients with care, and outlawed physical punishment. Pinel believed in the “basic goodness of all men,” which led him to be the first to remove chains and restraints from mentally ill patients (Mackler & Bernstein, 1966, pg 714).

Dorothea Dix played a great role in changing how society viewed the mentally ill in the early 1800’s. By raising awareness of the abysmal states of many institutions and gaining political support for her cause, she was able to establish new hospitals and ensure that they ran safely and more humanely (Kearney & Trull, pg. 12). Clark points out that she frequently returned to her established hospitals to ensure that they were running as she saw fit (Clark, pg. 36) With the improvements to institutions made by both Pinel and Dix, patients in institutions received all around better care and were able to prosper and rehabilitate as they never had before.

The first time after the Reform Movement that the institutionalization of people with schizophrenia and other mental disorders declined rapidly and continuously was the mid-1950’s (Nemade & Dombeck, Institutionalization & Deinstitutionalization). The reason for this was the creation of antipsychotic medication, particularly chlorpromazine, which was the first of the anti-psychotic drugs to become widely available (Warner, 2004, pg. 86). Warner goes on to explain the figures for New York State mental hospitals as an example. Until 1955, New York State mental hospitals held increasing residential populations of 2,000 patients per year. In the year 1955, 30,000 of these residential patients were given a new anti-psychotic drug, and the upward trend of 2,000 patients per year began to decrease in the years after by the following amount of residential patients:

1956: 500 patient decrease

1957: 500 patient decrease

1958: 1,200 patient decrease

1959: 2,000 patient decrease

(Warner, 2004, pg. 89)

King & Nazareth in their article *Community care of patients with schizophrenia: the role of the primary health care team* (1996) explain that these antipsychotics have a great effect particularly on the positive symptoms of schizophrenia, such as hallucinations, delusions, and disorganized or unusual thought patterns. Because of the lessening of visible symptoms of schizophrenia by anti-psychotics, these drugs make it possible for people with normally obvious symptoms of schizophrenia to live a more normal life. Nemade & Dombeck (Schizophrenia Medication Treatment Options) explain that chlorpromazine differed from previous schizophrenia treatments in that patents were actually able to live with fewer, less pronounced symptoms, or in some cases, live symptom free for a period of time, where before the 1950’s medication consisted primarily of tranquilization and restraint which did nothing to reduce the actual symptoms of the disorder.

Today, institutionalization is still an option for the treatment of schizophrenia. However, psychological treatments are commonly used before institutionalization. Kearney & Trull describe some psychological treatments of schizophrenia, including cognitive-behavioral therapy and support psychotherapies, which educates someone with schizophrenia about their disorder and how to live with it, social skills training, which practices social situations with a professional that can then be generalized to everyday life, and cognitive rehabilitation, which aims to help someone with schizophrenia practice attention, memory, and decision making (Kearney & Trull, pg. 372-734). Both Kearney & Trull and King & Nazareth see the benefits of community care as treatment for schizophrenia before institutionalization. Kearney & Trull describe two different types of community care, one in which the person may be placed in a group home with staff that acts as case managers, and another in which the person with schizophrenia lives independently but with frequent visits from psychiatrists and case managers, called assertive community treatment (Kearney & Trull, pg. 374). These methods of community care have been found to be at least as effective in the treatment of schizophrenia as residential institution, and to cost less than hospital care (King & Nazareth, pg. 233).

Modern day institutionalization is often used in cases when community care is not an option. This may be when the symptoms affect the person to the extent that he or she cannot function in society without careful monitoring, or when he or she has no family or friends to aid in the care and treatment of the disorder (Nemade & Dombeck, Institutionalization & Deinstitutionalization). Even so, institutions today have standards of accreditation that must be examined and updated annually, thus ensuring that the standard of care for the institutionalized never falls to the appalling state that it once was (The Joint Commission, 2011).

**Schizophrenia and Eugenics in the US and Germany**

Pernick (1997) tells us in his article *Eugenics and Public Health in American History* that the idea of eugenics as a form of improving the heredity and thus overall quality of human life was developed in the United States at the beginning of the 20th century, about 20 years before race hygiene was visible in Germany. Eugenics in the United States developed from the ideas of Charles Darwin and later Sir Francis Galton, and was considered an “artificial selection” that only sped up the natural selection that nature would eventually accomplish on its own. Snyder & Mitchell add that eugenicists viewed the disabled and the “feebleminded,” including those with mental disorders such as schizophrenia, as holding undesirable traits that would eventually, through procreation, spread throughout the entire country, making it weaker and weaker until it collapsed (Snyder & Mitchell, pg. 70). The solution to this seemingly inevitable collapse of society, then, was to weed out the undesirable - which here included the vagrant, feebleminded, and mentally ill - through sterilization, or as Charles Davenport said in 1910, “To dry up the springs that feed the torrent of defective and degenerate protoplasm (Friedlander, 1995, pg 6).” The United States went on to be the first to experiment with human eugenics, writing papers on this artificial selection and developing the first gassing chambers that influenced leaders in foreign countries including Germany, and most notably Adolf Hitler. Hitler closely followed all of the developments in American eugenics, and called American eugenicist Madison Grant’s book *The Passing of the Great Race* his “Bible,” in a letter of admiration to Grant (Black, 2003).

This influence that the United States had on other countries manifested most notably in Germany’s T4 euthanasia program, which began in 1939 though the idea of “race hygiene” was in place long before. Euthanasia in Germany began with a simple sterilization law put into place in 1933 that set a baseline for eugenic legislation passed afterward (Friedlander, pg. 23). The sterilization law mandated obligatory sterilization for those suffering from mental or physical disorders, particularly those considered hereditary, including feeblemindedness, schizophrenia, manic depression, epilepsy, Huntington’s Chorea, blindness, deafness, and a variety of physical deformities (Friedlander, pg. 26).

Hitler then moved toward more drastic measures, those that would rid society of “life unworthy of life (Friedlander, pg. 62).” These measures included the creation of the T4 euthanasia program. T4 leaders consisted of Hitler, his personal physician Karl Brandt, KdF head of adult euthanasia Viktor Brack, and other notable German eugenicists. In chapter 4, Friedlander explains that Hitler’s authorization of the T4 program allowed physicians to grant mercy deaths to institutionalized patients where they saw fit, the justification being that “the insane person himself is in no position to judge his situation (Friedlander pg. 84).” However, this was certainly not the case, and most of the time, the patients in the institutions were perfectly able to think and speak for themselves.

Emmi G. was diagnosed as schizophrenia and sterilized at 16 years old. She was later sent to Meseritz-Obrawalde and killed there on December 7, 1942. Her death was made to appear natural, but was in reality due to an overdose of tranquilizers given to her by the institution’s medical personnel (Holocaust Encyclopedia). Emmi’s death, along with the deaths of many other girls like her who had already been sterilized, proves that T4 was not stopping only the hereditary spread of “undesirable traits,” but putting a stop to anyone who possessed those traits. If T4 was merely stopping the “undesirables” from procreating, there would be no reason to have girls like Emmi G. killed after they were already sterilized. Emmi’s diagnosis of schizophrenia at the young age of 16 also calls into question the accuracy of the diagnosis. It is difficult to find information about the early life of Emmi G and other T4 victims, but according to Murray et al in *The Epidemiology of Schizophrenia,*the median onset of schizophrenia in women typically occurs in early adulthood with an average of 25 years old, with another peak of onset for some at 45-50 years (Murray et al, 2003, pg. 136) Not only was Emmi G. very young for an accurate diagnosis of schizophrenia, Kearney & Trull point out that most psychologists and psychiatrists do not diagnose psychotic disorders until adulthood due to frequently changing behavioral patterns of children and the fact that many symptoms of psychotic disorders are very vague and cannot be immediately classified into a certain disorder. This raises uncertainty as to the accuracy of Emmi G.’s diagnosis and circumstances surrounding her death.

Another murky case of hasty diagnosis, sterilization, and ultimately death centers on Helene Melanie Lebel. Helene was 19 when she suffered a major breakdown and was admitted to Steinhof Psychiatric Hospital in Vienna. After her condition had improved, she was not allowed to leave and was supposedly transferred to Brandenburg, Germany, where she was killed in the hospital’s gas chamber (Holocaust Memorial Museum). While it is commonly doubted that she was actually transferred to Brandenburg, a transfer that would have taken a great deal of time and money to move Helene from where she was initially residing in Vienna all the way to central-northern Germany, it is now also skeptical that she ever suffered from schizophrenia. It was discovered by the public years after her death that Helene had witnessed a plane crash very close by her home, an accident that injured a girl her age. After this, she began to show the symptoms of post-traumatic stress disorder (PTSD), a mental disorder that can occur at any age and follow any traumatic event or witnessing of traumatic event, including a personal attack, rape, flood, or in this case, plane crash (PubMed Health). Symptoms include flashbacks or “re-living” the event, avoiding situations that remind one of the event, emotional detachment, memory loss, depression, and many other various life-disrupting symptoms. It is possible that Helene Lebel, after witnessing a plane crash and injury to others a very short distance away from herself, began suffering from PTSD symptoms that disrupted her life, and was institutionalized. Once she felt her symptoms had alleviated, she had already been hastily diagnosed with schizophrenia and put in line for euthanasia through the T4 program.

Emmi G. and Helene Melanie Lebel were two girls who could have lived perfectly normal lives without the interference of T4 euthanasia, as their diagnoses of schizophrenia may not have even been accurate. However, even those who were correctly diagnosed with schizophrenia or other mental disorders during the period of German eugenics could have lived prosperous lives. Not only are there numerous treatments that can be implemented without institutionalization to alleviate symptoms of schizophrenia, but 74 percent of people diagnosed with schizophrenia show evident improvement in symptoms over time, and 78.8 percent of people with schizophrenia hold jobs (Kearney & Trull pg. 375). Nemade & Dombeck agree that, especially with early treatment, long-term prognosis for schizophrenic people is generally positive. Ten years after the first diagnosis of schizophrenia, about 50 percent of people have undergone an almost complete recovery and another 25 percent feel that their symptoms have significantly decreased (Nemade & Dombeck, Prognosis and Recovery). For these reasons, one can easily see the front that the T4 program was putting on by providing so many mercy deaths when actual treatment for the mental disorders would have aided in the recovery of a majority of patients. However, the goal of T4 and German euthanasia was not recovery of the disabled, but eradication, and by August 1941, 70,000 victims had already been euthanized (Friedlander, pg. 85). However, euthanasia did not stop here, as this was only the first wave. By the time euthanasia in Germany had finally come to a complete standstill in 1945, the total number of psychiatric patients killed was estimated to be between 200,000 and 275,000. Of those, the number of specifically schizophrenic patients killed is estimated to be between 100,000 and 137,500 (Torrey & Yolken, 2010).

**Demographics of Schizophrenia**

Schizophrenia holds a lifetime prevalence of about 0.33 to 0.72 percent of the population, meaning that 0.33 to 0.72 percent of the population develop schizophrenia at some point during their lives (Kearney & Trull, pg. 357). This agrees with Eaton’s review of schizophrenia incidence studies, which show results for an annual incidence rate of between 0.04 and 0.58 in every 1000 people, meaning that between 0.04 and 0.58 people in 1000 are newly diagnosed with schizophrenia each year (Eaton, 1999).

However, prevalence of schizophrenia is not quite uniform. Schizophrenia is more commonly diagnosed in ethnic minority immigrants, people living in urban areas, and people with lower income levels (although it is possible that prevalence of schizophrenia causes the lower income levels, rather than vice versa). Kearney & Trull speculate that this may be due to increased risk of malnutrition, higher rates of substance abuse, social isolation, and lack of adequate mental health treatment services in these groups. (Kearney & Trull, pg. 359-365).

Murray et al references the Ten Country Study, one of the most commonly used pieces of research to observe prevalence of schizophrenia throughout different regions of the world in the past. However, the study was originally run using “narrow” schizophrenia symptoms, or obvious positive symptoms, only to determine the percent of each country’s population that suffered from schizophrenia, rather than all positive and negative symptoms as a whole. This resulted in the Ten Country Study commonly being used to prove that prevalence of schizophrenia exists in uniformity across the world. In 1992, the study was reevaluated using the 1992 WHO’s criteria for schizophrenia in conjunction with the most recent follow up data of the Ten Country Study to calculate new annual incidence rates of schizophrenia per country (Murray et all, pg. 19-22). This resulted in much higher annual incidence rates of schizophrenia in Chandigarh (India) Trinidad, and Barbados, and Jamaica, than all of the other countries evaluated that was not present before reevaluation (see table below, S+ = original data, SPO = revised data). This reevaluation shows that developing countries in fact have a higher annual incidence rate of schizophrenia than already developed countries, when there was before believed to be no difference.

Selected Incidence Studies (Revised Ten Country Study)

Annual Incidence Rates per 1000

Site S+ (Narrowly Defined) SPO (Broadly Defined)

Chandigarh Urban 0.09 0.25

Chandigarh Rural 0.11 0.35

Jamaica 0.21 0.24

Trinidad 0.16 0.22

Barbados 0.28 0.32

Moskow 0.12 0.22

Aarhus 0.07 0.11

Dublin 0.09 0.14

Nagasaki 0.10 0.16

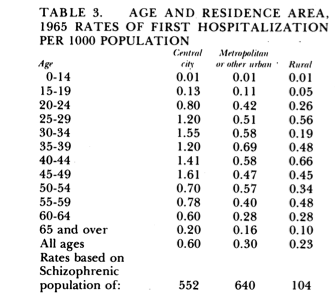
Nottingham 0.14 0.18

(Adapted from Murray et al Table 2.1: Selected Incidence Studies, pg. 20)

Of the regions studied, Trinidad, Barbados, Jamaica, and the city of Chandigarh were considered still developing. Though there is not concrete evidence that schizophrenia occurs at a higher incidence rate in less-developed countries, the outcome of the revised Ten Country Study agrees with the Kearney & Trull in that schizophrenia is more common in those with less income and lack of medical and mental health treatment.

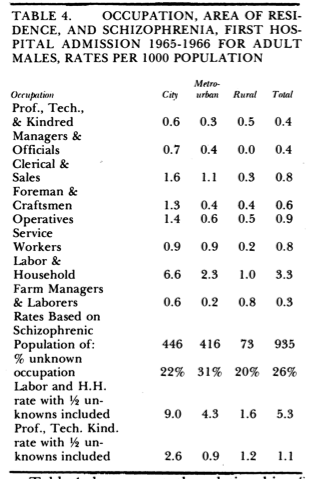
Bhugra states in his article “The Global Prevalence of Schizophrenia” that one of the reasons it is so difficult to obtain an accurate prevalence rate of schizophrenia in countries around the world is that “cross-cultural research focuses on similarities, not differences (Bhugra 2005).” This means that many researchers focus on symptoms and traits of schizophrenia that are similar and common to use as a model for their research, and disregard data that may include vague or negative symptoms, as they are more difficult to code. This is detrimental to discovering an accurate cross-cultural prevalence rate because disregarding certain less visible symptoms of schizophrenia will eliminate a great amount of data and this elimination can easily be culturally biased toward certain symptoms, which would certainly skew a cross-cultural prevalence rate (Bhugra, 2005).

Eaton (1974) conducted a comprehensive study of the demographic differences of schizophrenia in rural, “suburban,” and urban areas, while factoring in the impact of mobility, stress, and utilization of facilities in each of those areas. Eaton first compared age and residence area to determine that first hospitalization for schizophrenia occurs earliest in cities (age 30-34), later in suburbs (age 35-39), and even later in rural areas (age 40-44) (Eaton, pg. 294, see table 3 below).



(Table 3: Age and Residence Area from Eaton, pg. 294)

Next, using occupation to determine what social class a person was considered to be a part of, occupation was compared to area of residence in order to determine the relationship of relative social class to schizophrenia prevalence. In general, those with more prestigious occupations, thus higher incomes and ultimately mid-upper class, had lower prevalence rates of schizophrenia than those who worked as laborers. While these results were not statistically significant, it is clear that occupation has a much higher correlation to prevalence of schizophrenia in cities than in rural areas (Eaton, pg. 294, see below).



(Table 4: Occupation, Area of Residence, and Schizophrenia, from Eaton, pg. 294)

The effect of socioeconomic status in Eaton’s study should be examined carefully, not solely because socioeconomic status is classified by occupation rather than an official census, but because this could be an example of a directionality problem – one cannot know with certainty if schizophrenia causes a lower income, or is lower income is a factor in the development of schizophrenia (Kearney & Trull, 359).

In a more recent study, Mortensen et al used a population of 1.75 million people via Denmark’s Civil Registration system for their study “Effects of Family History and Place and Season of Birth on the Risk of Schizophrenia (1999).” Through the Civil Registration System, the researchers identified 2,669 cases of schizophrenia in which the person with the disorder was born between 1968 and 1993. Using the pre-recorded information in the Danish Psychiatric Registrar enabled researchers to see important demographic information regarding each person diagnosed with schizophrenia while keeping their identities anonymous and, with the huge population of the study, left a very small margin for error and variance in results. The researchers found, consistent to Eaton’s 1976 study, that the risk of schizophrenia was highest for those born in cities and lowest for those born in rural areas as well as Greenland (which can be considered rural, as it is the least densely populated dependencies in the world) (Mortensen et al, pg. 603-605, see below).



(Table 1: Distribution of 2669 cases of schizophrenia… from Mortensen et al, pg. 603-605)

Murray et al lists obstetric complications, increased maternal exposure to infectious disease, drug abuse, psychosocial stress, and social isolation as some explanations for the higher prevalence of schizophrenia in urban areas (Murray et al, pg. 53-55). However, when attempting to gather demographics of a disorder such as schizophrenia, in which many cases are not registered, many people do not receive treatment, and symptoms may vary from culture to culture, evidence is difficult to gather and difficult to explain. However, with the help of Registrars such as Denmark’s Civil Registrar used in Mortensen’s examination of schizophrenia in urban vs. rural areas, these demographics are becoming more and more accessible.

**Societal Reactions to Schizophrenia**

Nemade & Dombeck (Schizophrenia Stigma and Violence) believe that the current stigma of violence in schizophrenic people has risen from the institutionalization of schizophrenic individuals in history. The need that society felt to isolate schizophrenic and mentally disabled people from the nondisabled gave way to the false notion that schizophrenic people were dangerous. Angermeyer’s 2006 literature review, “Public Beliefs about and attitudes toward people with mental illness: a review of population studies” examines 33 national and 29 local studies to determine the modern public view on mental illness. Results show that negative public opinion has definitely lessened in the previous 15 years, but there are still common misunderstandings about particular disorders and how they manifest, as well as a decreasing but still present stigma of the dangerous and unpredictable mentally ill patient. Researchers also found that there is a distinct correlation between familiarity with a specific mental illness and acceptance of people with that illness, in that the more contact one has with a certain mental disorder, the more accepting of the disorder he will be (Angermeyer, 2006, pg. 166-169). Though stigma toward people with mental disorders has definitely lessened in the past few decades, merely being labeled “mentally ill” has an effect on the diagnosed person. One anonymous institutionalized patient says,

“I have often been fraught with a profound guilt over my diagnosis of schizophrenia…I had little idea how dehumanizing and humiliating the hospital would be for me…I felt I had partly lost my right to stand among humanity…and that for some people I would forever be more something of a subhuman creature… Mental health professional often treated me…as if I were a stranger or alien of sorts, set apart from others by reason of my label.”

(Warner, pg. 193)

Warner goes on to explain that many people labeled as mentally ill or having a mental disorder begin to see themselves as others do and develop a negative self image (pg. 195).

The media is another factor in societal reactions to mental illness. Disability portrayed in media and film is a powerful form of educating the masses, most of the time incorrectly. Film critic Linda Williams’s structural dissection of film bodies portrays three common stereotypes of the disabled seen most often in film: faked impairment (comedy), inborn monstrosity (horror), and maimed capacity (pity) (Snyder & Mitchell, pg. 165). Unfortunately, most common film characters with mental disabilities, including schizophrenia, are very often found in horror films. Hannibal Lecter, protagonist of the films *Silence of the Lambs* (1991), *Hannibal* (2001)*,* and *Red Dragon* (2002)*,* for example, is one of the most famous horror movie villains of all time and is most notably remembered locked up in an asylum. Michael Meyers of the *Halloween* series (beginning in 1978), one of the oldest horror film killers, spends 15 years of his life in a high security asylum. As Snyder & Mitchell point out, “like film plots, the disabled body itself can solidify a form of visual shorthand (pg. 164).” The visual shorthand that most viewers receive through watching the multitude of horror movies in which the mentally disabled possess a bodily display of inborn (or outborn) monstrosity is that mental illness is consistent with danger and violence.

However, as Angermeyer found, societal stigma of those diagnosed with mental disorders is decreasing. The more people come into contact with others that have diagnosed mental disorders, the more they will understand the irrationality of the violent stigma that schizophrenia and other similar disorders hold.

Schizophrenia is a mental disorder that holds a lengthy and fascinating history. From as far back as it can be traced through literature, humankind has been struggling with psychotic disorders and clusters of symptoms that make up schizophrenia. After an extensive battle through institutionalization, the Reform Movement, a second wave of institutionalization in the form of widespread eugenics, and at last deinstitutionalization, there is finally hope for the treatment and social integration of people with schizophrenia and similar mental disorders, who were in the past not allowed or able to be part of society. With the publication of more scholarly articles regarding schizophrenia, medical breakthroughs treating its symptoms, and a steady continual decrease of stigma, the prognosis of schizophrenia, though marginal, is continuously improving.

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