CHAPTER II

GENERAL DESCRIPTION OF THE OBJECT OF THE STUDY

II.1. Description of Schizophrenia

Phillip G. Zimbardo (1996:656) describes schizophrenia as a severe form of psychopathology in which personality seems to disintegrate, thought and perception are distorted, and emotions are blunted. Schizophrenic, a person who suffers from schizophrenia, is generally known as an insane person.

It was Blueler (1911) who offered the using of "schizophrenia" for this disorder because he thought that it could perfectly represent the main symptom of schizophrenia, that is the splitting of mind. This condition makes schizophrenics possess lack of a coherent relationship between thoughts and feelings.

Unlike people suffering from mood disorders, schizophrenics usually do not experience extreme emotions. In fact, they may experience "flat" affect, showing little or no emotions even in the face of happy or sad events. Those who display emotions often do so inappropriately – laughing while telling a sad story or crying for no apparent reason (Berstein *et al.*, 1991).

Lack of motivation and social skills, deteriorating personal hygiene and an inability to function are common characteristics of schizophrenia. Schizophrenics also lose the sense of themselves and interest in anything of their surrounding (a condition known as autism). When schizophrenics enter this phase, they will give no response to others' action. They will live in their own world.

What is interesting is the fact that the consciousness and the intelligence of the schizophrenics do not decrease. They are still as conscious and intelligent as when they were sane (Maramis, 1995:221). It is said that their consciousness is "changed". It does not increase or decrease, yet is not normal (Maramis, 1995:104). Still, they could tell others about their experiences and feelings.

They sometimes suffer from depersonality or double personality. When they do, they will identify themselves as a desk, a tree (depersonality), the next president of his country or a prince (double personality).

To get to know about schizophrenia better, there are some topics to be discussed; they are:

II.1.1. Types of Schizophrenia

There are five major types of schizophrenia known in the society (Zimbardo and Gerag, 1996:657), namely:

1. disorganized type

   People who suffer from this type of schizophrenia will display incoherent patterns of thinking and bizarre and disorganized behaviour. Emotions are inappropriate to the situations. These people will smile or laugh when listen to sad stories, cry when others are happy, or giggling for no apparent reason.

2. catatonic type

   The main characteristic of the catatonic type of schizophrenia is a disruption in motor activity. A schizophrenic's movement alternates between total immobility, well known as stupor, and wild excitement.

For certain period of time, person suffers from this type of schizophrenia often remains motionless in a bizarre and uncomfortable position. During this time, they will give no reaction to any stimulus from their environment.

3. paranoid type

   Individuals suffering from this form of schizophrenia experience complex and systematized delusions which usually focus around the following themes:

   - delusion of persecution
   - delusion of grandeur
   - delusion of jealousy
   - delusion of reference
   - delusion of sin and guilt
   - delusion of influence

4. undifferentiated type

   Schizophrenics of this type possess prominent delusions, hallucinations, incoherent speech, or disorganized behaviour that fit the criteria of more than one type or of no clear type.

5. residual type

   Persons diagnosed as residual type of schizophrenia have usually suffered from a major episode of schizophrenia, but are currently free of major positive symptoms, such as delusions or hallucinations. The presence of the disorder will be recognized by minor positive

symptoms or negative ones like flat emotion. A diagnosis of this type of schizophrenia may indicate that the person's disorder is entering remission.

II.1.2. Causes of Schizophrenia

There are many researches have been done in order to investigate the causes of schizophrenia. Yet, there is no single theory that can adequately account for all forms of schizophrenia. Systematic research suggests that many different factors play a role.

(a) genetic factor

Schizophrenia tends to run in the families. The closer the family relationship between two individuals the higher the degree of risk of suffering from schizophrenia. Three independent lines of research - family studies, twin studies, and adoption studies - point to a common conclusion, that is persons related genetically to someone who has schizophrenia are more likely to become affected than those who are not (Zimbardo and Gerag, 1995:660). Still, most people with schizophrenic relatives are not schizophrenics. What may be inherited is a *predisposition* towards schizophrenia, not this disorder itself. Only when a genetically inherited predisposition is accompanied with stressful condition does schizophrenia develop.

(b) biochemical factor

A great deal of research is examining the possibility that *neurotransmitters*, especially dopamine, play a role in causing or at least intensifying schizophrenics' thought and behaviour (Berstein *et al.*, 1991:605).

Schizophrenics' symptoms may be the result of an increase in the activity of nerve-cells that use dopamine as their *neurotransmitter*. This hypothesis arose in 1950's based on the development of a new group of drugs, the *phenothiazines* that dramatically relieved many schizophrenics' symptoms (Zimbardo and Gerag, 1996:662).

(c) brain structure factor

Another approach to the study of causes of schizophrenia is to look for abnormalities in the brains of individuals suffering from this disorder. Much of this research now relies on brain imaging techniques which allow direct comparisons between the structure and functioning of the brains of individuals with schizophrenia and normal people (Zimbardo and Gerag, 1996:662).

Data from autopsies, X-rays, PET scan, and magnetic resonance images have spawned theories that suggest a relationship between schizophrenia and other brain abnormalities. Among those abnormalities are shrinking or deterioration of cells in the cerebral cortex or cerebellum, enlargement of the brain's fluid-filled ventricles, disorganization of cells in the *hippocampus* (an area involved with the expression of emotions), reduced blood flow in certain parts of the brain, abnormalities in *brain lateralization*, and the patterns of dominance of the cerebral hemisphere over the other physical anomalies (Berstein *et al.*,1991:605).

Not all schizophrenics display such abnormalities, but the relevance of brain disorder for schizophrenia is supported by evidence that the specific nature of the brain abnormalities may be related to the person's symptoms.

(d) cognitive factor

One theory proposes that individuals with schizophrenia suffer from attentional deficits which make them ignore important environmental and cultural cues that most people use to regulate their behaviour (Zimbardo and Gerag,1996:663).

Research by Brendan Moher (1996) focuses directly in attentional disturbance in language processes. Maher suggests that the speech of individuals with schizophrenia may be a result of deviant processing. At that point, a personally relevant, but semantically inappropriate, word is used.

Researches also suggested that schizophrenics typically reverse usual procedures for reality testing. Unlike others, they use their inner experiences as the criteria against which they test the validity of outer experience (Zimbardo and Gerag,1996:663).

II.1.3. Symptoms of Schizophrenia

Blueler divided symptoms of schizophrenia into two major groups; they are (1) primary symptoms includes disturbance of thought, disturbance of thinking, and disturbance of motor behaviour, and (2) secondary symptoms which includes hallucinations and delusions (Maramis, 1995:218).

- Disturbance of thought

Schizophrenics do not think or speak like others. Problems of schizophrenia seem to stem from the break down in the capacity for selecting attention. Normally people can focus their attention on certain stimuli while largely ignore others. This is not true for schizophrenics (Baron, 1995:574). The content of schizophrenic thinking is also disturbed. Often, it includes a bewildering assortment of delusions. Delusions of persecution are among the most common (Berstein *et al.*, 1991:603).

- Disturbance of emotion

This disturbance involves inappropriate or unusual emotional reactions. Some schizophrenics show almost no emotion at all. Others show emotion, but their reactions are inappropriate. They may smile when describing a painful abuse or when receiving tragic news and cry when telling a joke.

- Disturbance of motivation

Most schizophrenics cannot make decision about what to do.

- Disturbance of motor behaviour

This disturbance involves unusual actions. These can take an incredible range of forms and usually take a certain length of time. The positions are very bizarre and uncomfortable.

- Delusion

Delusion is a false persistent beliefs maintained in spite of evidence to the contrary. It implies belief in something that is contrary to fact or reality, resulting from deception or misconception. Schizophrenics believe that external events are

specially related to them personally. When watching others talk, schizophrenic thinks that they talk about him.

- Hallucination

Hallucination is an apparent perception of sights or sounds that is not actually present. Schizophrenics usually hear voices – of God, friends, relatives, and doctors – which talking about, threatening, or shouting at them.

II.2. Language of Schizophrenics

Affected by their psychological condition, a schizophrenic possesses a rather "different" language. Schizophrenics' language shows handicapped yet creative aspects. It can be recognised by the existence of changes in grammar and syntax, such as string of words which is not syntactical, cutting of words or deletion of essential elements of word, phrase, clause, or sentence (Chauchard, 1993:80).

Schizophrenics often create words of their own (Baron, 1995). They introduce the existence of what is called *neologism*, that is giving new meaning for established words. Instead of saying the already existing words, they, sometimes, use new words which they consider to have the same meaning with the former. For example, they will use words such as *littlehood* and *crimery* for childhood and bad action, respectively (Baron, 1995:574).

In extreme cases, their words seem to be totally jumbled into what psychologists term a *word salad* (Baron, 1995:574). They mix the words without considering whether the words take the correct place in the sentences they utter. It

seems that they talk just because they have to let the ideas running in their minds out.

There is also glossolalia. Glossolalia is apparently ecstatic utterances of usually unintelligible *speechlike* sounds. Schizophrenics utter it the way they talk in their native language, but it has no meaning at all. These sounds are merely strings of words which are not listed in the dictionary and cannot certainly be understood by others.

There is also one interesting characteristic of schizophrenic unique language. These people tend to emphasis the importance of rhyme and phonetics, instead of syntax and semantics (Chauchard, 1993:81). They like to repeat words which have similar sounds and very often they begin a sentence with word which is the final word of the previous sentences.

The strangeness of schizophrenics' language can also be seen from the theme of their talking which is usually uncommon, especially to those who suffer from hallucinations and delusions.

Despite the occurrence of those language disturbances, the schizophrenics can still communicate with others (Chauchard 1983: 80).

II.3. Description of RSJD Menur

RSJD Menur was built in 1977. It is located in Menur street number 120 in Surabaya. Constructed on a pretty large area, that is, 38.070 m2, Menur has 350 beds for patients which are divided into 9 rooms. About 75 percents of them are

occupied by schizophrenia patients (Annual Book of RSJD Menur Surabaya, April-October 2000 edition).

The basic principle of the existence of RSJD Menur is to provide a supporting environment for individuals who suffer from mental illness. To avoid an uncomfortable atmosphere and to give what doctors know as a *milieu therapy*, that is a condition where environment affect the healing process, rooms in RSJD Menur were not made as hall, but rather they were arranged in a certain way so that patients will feel comfortable as in their own homes.

The non-physic-environment, which consists of doctors, nurses, and workers, will also support this condition. They were asked to socialize with the patients. The programmes the hospital offers encourage the patients to behave as normal people. There are music therapy, play therapy, making handicraft and other useful activities. The patients are also asked to take care of their room as well as their self-hygiene.

II.4. Description of the Respondents of the Study

After doing an observation on the eight schizophrenics being chosen for about a week, the writer finally decided to take all male patients since the writer found them very "active". They can socialize and communicate with others although, sometimes, incoherencies occur.

What the writer means by communicating is the process of asking questions and giving response between the respondents and the writer.

The four respondents in this study are:

(1) Mr. T, 40 years old.

He suffers from paranoid type of schizophrenia. He comes from a city in Central Java and has been living in RSJD Menur for about a year. He talks mostly about politics and his destiny to be a president. He also likes to discuss about his family: a wife and a three-years-old daughter.

(2) Mr. Ca, 30 years old.

He also suffers from paranoid type of schizophrenia. He comes from a city in East Java. He has been living in RSJD Menur for about one and a half years. Besides talking about his family, he also likes to talk about his bank account. Over and over he talks about the causes of his insanity and his staying in RSJD Menur which is always inconsistent.

(3) Mr. Sy, 31 years old.

He suffers from paranoid type of schizophrenia. He believes that he is always accompanied by genies and angels. He mostly talks about Islam and his ability to make woman like him. Very often, he murmured Islamic prayers.

(4) Mr. Wo, 52 years old.

He suffers from residual type of schizophrenia. He likes talking about work ethics and its importance in human beings' lives.

CHAPTER III

PRESENTATION AND ANALYSIS OF THE DATA