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Psychological and Social Aspects of Negative Symptoms

JOHN S. STRAUSS, JAAK RAKFELDT, COURTENAY M. HARDING and PAUL LIEBERMAN

Our reintroduction of the concept of negative symptoms in schizophrenia (Strauss *et al*, 1974) has been followed by much productive research on this topic. As in the work of Andreason, Crowe, and others, the focus of most of this research has been on improving descriptive assessments of these symptoms (Andreason, 1982) and exploring their biological correlates (Crowe, 1981). This work has been extremely important, but psychological and social aspects of negative symptoms are also important (Barton, 1959; Wing & Brown, 1970; Gruenberg, 1967), and in these areas there has been little research. Nevertheless, it is crucial to explore possible psychological and social factors in negative symptoms in order to understand the symptoms more fully and to provide a basis for more adequate prevention and treatment. It is also important to clarify psychological and social factors in these symptoms to provide a basis for more effective biological research, since the heterogeneity of negative symptoms at a psychological level could hide significant biological correlates.

In this paper we will explore the possible psychological and social aspects of negative symptoms utilising information from our intensive longitudinal studies and from large sample studies, first-person accounts, and clinical experiences. Based on these sources, we will develop two hypotheses: (a) Negative symptoms arise in many instances as responses to extremely difficult psychological and social situations. These symptoms may even serve to help the person with schizophrenia survive. In such instances, the term 'negative symptoms', although descriptively useful, may be misleading, since these symptoms may reflect active coping on the part of the patient; (b) Negative symptoms have a psychological and social impact on the further course of disorder. Negative symptoms may provide some psychological solutions for the problems patients encounter, but these symptoms may also generate a cyclical feedback process that removes patients from social functioning and in this way reduces the likelihood of improvement. This impact may contribute to the poor prognostic implications of negative symptoms.

Thus, in this paper we develop further our thesis that as part of understanding severe mental disorders and improving their treatment, one must use an interactive developmental model (Strauss & Carpenter, 1981). This approach requires viewing persons who have these disorders as complex evolving systems operating in biological and social contexts. Negative symptoms arising from psychological, biological, or social origins may then influence the further evolution of any or all of those domains.

To explore the many aspects of negative symptoms various approaches are necessary. In spite of the advances made in developing rating scales (Andreasen, 1982), such ratings may not tap underlying psychological processes adequately. More intensive and extensive exploration is also essential. For example, Bouricius (1989) reports an instance in which her son had been diagnosed as having schizophrenia and was viewed as having flat affect at a time when his appearance and behaviour were dull and apathetic. At the same time, however, he was writing very emotionally charged poetry. Noting associations between negative symptoms and the psychological and social contexts in which they emerge can help prevent naive interpretations from brief descriptive reports and provide important clues to psychological processes that might contribute to the generation of the symptoms (Strauss & Hafez, 1981; Strauss *et al*, submitted for publication). Thus this exploration suggesting that negative symptoms are often responses to difficult psychological and social situations uses more detailed description of patients' reports and contexts than is found in traditional symptom ratings.

Possible psychological and social sources of negative symptoms

Reports of patients from our own intensive studies (Strauss *et al*, 1985), reviews of first-person accounts (*Schizophrenia Bulletin*, 1987), and clinical experiences suggest several specific psychological and social contexts in which negative symptoms often arise. These sources suggest ten different kinds of situations that may contribute to these symptoms. The following is a list of these situations with illustrative examples.

1. The pain of relapse into positive symptoms

A schizophrenic patient considered by his psychiatrist to have an 'anhedonic syndrome' described in an interview with one of the investigators (JS) a sequence of factors occurring in his illness. This young man had been a motorcycle racer. He then started developing schizophrenia with delusions of persecution and threatening auditory hallucinations. When he was engaged in motorcycle racing, especially if he were close to winning, these symptoms would become unbearably intense. The patient described this as such a horrible

experience that he finally gave up motorcycle racing entirely, an activity that had been one of the few pleasures of his life.

2. The loss of hope and self-esteem

One person seen in our intensive longitudinal study who had a history of 12 years of schizophrenic disorder had sunk drastically in quality of life during and between his psychotic episodes. Before the onset of his illness, he had been a highly skilled craftsman. He had been married with one child and was involved with his mother and siblings. Over the years however, he was repeatedly admitted to hospital. When he was able to work, it was as an unskilled labourer. He was divorced, out of touch with his child, and lost contact with other family members as well. He had no friends. How many people could maintain motivation and involvement under such a decline? But somehow, this patient had kept trying, although more and more feebly.

Most recently, he had been admitted to hospital with yet another psychotic episode. In the subsequent 3 months, although still slightly apathetic and withdrawn, he improved gradually and had started to become more autonomous. When noting in a research interview that he had improved, he added: 'I'm almost afraid to think about it. How long will it be until the next time?' Given this attitude, it is perhaps not too surprising that when seen in a follow-up interview 1 month later the subject had withdrawn further. He had been spending most of his time in bed and had been advised finally by his clinician that he should apply for disability payments and would probably not be able to return to work.

3. The possibility of impulsive or bizarre behaviour

Negative symptoms may arise when the patient has had problems acting impulsively or acting bizarrely. In some instances it appears as though massive apathy and withdrawal are mechanisms for avoiding such socially or personally destructive behaviours by damping down overall behaviour. In psychotic states, when fine control of action and thinking is severely compromised, a massive withdrawal might be the only way in which display of bizarre behaviour and thoughts, or actual destructiveness, can be avoided.

4. Problems in finding a new identity as non-patient

Another situation in which negative symptoms may arise is when the patient confronts the difficulties of needing to find an identity that is not one of being sick. An example of the intensity of this problem was given by one subject in our intensive longitudinal study. This subject has improved considerably over the last several years and was now confronting this issue. She had not developed negative symptoms, but reflected how much she was tempted to give up and withdraw. This young woman wondered during a follow-up interview whether she was going 'crazy' because as she had become better she was losing the structure of her life that had been provided by her illness. She was no longer in treatment other than receiving low-dose neuroleptic medication. She did not want to associate with other patients or former patients. On the other hand, people that she had known prior to her illness now had families and jobs. Having neither, the subject felt out of place with them. In addition, she was perplexed as to how she was going to function in the world as a 'normal'. With these concerns and the feelings they generated, she wondered whether she was going crazy again. Other subjects described being sick as an occupation in itself — a full-time career. One subject told us how difficult it was to give up being sick with its constant self-focus. This subject, like the other, also stated that being sick provided an entire framework for relating to others and receiving help from them.

5. The feeling of guilt for past dysfunction

One mother (DuVal, 1987), who had had repeated psychotic episodes, described poignantly her vague awareness during these episodes that they were harming her child who witnessed them. Often people with schizophrenia describe the guilt they feel at being unable to perform in the roles in which they have previously taken pride and also from the actual psychological or physical harm they might have done to their loved ones during the psychosis. During the process of improvement with its increasing awareness of environment, these realisations create for patients a further burden and a pressure to withdraw and give up.

6. The potential threat of entering complex stressful social situations

For many patients, particular kinds of social and occupational situations may be extremely stressful, possibly even contributing to symptom recurrence. Interpersonal closeness, for example, is often extremely difficult for some persons with schizophrenia. Negative symptoms may arise from fears of such situations. The symptoms may be reinforced and maintained by also providing a mechanism for avoiding the threat or even the possibility of such a relationship.

7. Situations where the person is rendered helpless from the disorder, from environmental features, or both

Persons with schizophrenia may find all their paths to improvement blocked. This may be especially true for people with repeated psychotic episodes who come from

low socio-economic classes, have few skills, and are isolated from family and friends. Here, too, there may be the possibility of secondary benefit from negative symptoms. As Schmale has pointed out in another context (Schmale, 1964), giving up under overwhelming conditions may not be as maladaptive as it seems. Giving up at least offers the possibility of recruiting help from others in the social context if such help is available at all.

Three environmental contributors to negative symptoms

Beyond the negative symptoms possibly arising from the person's experience with the disorder itself as described above, these symptoms may also be associated with the following specific social-environmental characteristics.

8. Institutionalisation

Behaviours reflective of negative symptoms associated with long-term institutionalisation have been discussed in detail by other authors (e.g. Barton, 1959; Wing, 1962; Goffman, 1961).

9. The social benefit system

Although helpful for some, benefit systems sometimes punish patients who attempt to recover. As is so often true, one can see the situation facing a person about to improve by observing someone with schizophrenia who does not have negative symptoms and thus encounters the problems. One of our subjects, a 23-year-old woman with a 6-year history of psychotic symptoms, was able to work her way through college and part way through graduate school. She did this while at the same time working full-time at a skilled job. She accomplished such feats in spite of recurring symptoms and the side-effects from her psychotropic medications. However, because she then began to earn a modest salary, she was no longer eligible for welfare benefits. In addition, she had to pay for her own medications and treatment. As a result, she remained constantly in debt while only being able to support herself slightly above a poverty level. As she got better, she was thus far worse off materially and financially than she had been when she received disability benefits.

10. The stigma of schizophrenia

Stigma (Scheff, 1981) is a social situation that seems likely to contribute with particular power to the development of negative symptoms. Such an evolution is consistent with the concept of secondary deviance (Lemert, 1967), the reaction people often have to being viewed as defective, in this case as a mental patient. The reaction to being stigmatised often includes the acceptance of the role and loss of other strengths. This sequence may be influenced by many things including the intensity of the stigma, the severity or chronicity of the disorder, personality traits of the person, and pressures and supports of society.

Beyond these ten psychological and social situations, as further evidence for the hypothesis that psychological and social factors may be sources of negative symptoms, it is important also to note environmental situations that appear to reduce these symptoms. The helpful roles of modest increases in interpersonal contact or useful occupation have been discussed in many reports (Wing, 1962; Breier & Strauss, 1984). More striking changes in environmental situations may also have a salutory effect. There are many reports of withdrawn chronic schizophrenic patients who take leading roles in rescue operations during a flood or a fire, helping save other patients or even helping to organise the general rescue procedures. Only slightly less dramatic are the more systematic reports (Clark, 1988) describing how chronic schizophrenic patients participating in a challenging, engaging activity like a canoe trip begin to communicate, relate to each other, show pleasure, and take an increasingly active role in the venture. Characteristics of novelty, challenge, interpersonal support, trust, and free choice seem to be key factors in such situations.

The psychological and social impacts of negative symptoms on course of disorder

One of the most striking aspects of negative symptoms has been their prognostic power. This has been shown in several large-sample short-term studies (Strauss *et al*, 1974). It has also been found to a lesser extent in at least one carefully conducted long-term follow-up (Harding *et al*, 1987*a*). What is the mechanism for this prognostic effect? One possibility is that negative symptoms contribute to poor prognosis by cutting the person off from potentially helpful environmental resources. Although negative symptoms may help patients avoid or cope with certain aspects of their life situation, these symptoms may also generate positive feedback mechanisms that maintain or exacerbate the disorder with its dysfunction (Strauss *et al*, 1985). There is evidence, for example, that in several mental disorders work and social relationships may prevent decompensation or help people improve (Brown & Harris, 1978; Henderson, 1981; Breier & Strauss, 1984; Strauss *et al*, 1981). Negative symptoms usually undermine functioning in these life contexts. Patients who are too withdrawn to work, who are too apathetic and without affect to form social ties, cut themselves off from the very sources that could provide motivation, structure,

hope, material assistance, and advice. Furthermore, vocational rehabilitation programmes often systematically exclude persons with low motivation. Even the treatment system may give up on the patient with negative symptoms, making fewer resources available.

Discussion

Why are negative symptoms so important in schizophrenia when there are so many other disorders that also engender despair, fear of recurrence, and similar problems? One possible answer is the severity of the stigma with which society, (including the patient) views schizophrenic disorders. The diagnosis of schizophrenia is almost unique among mental disorders in terms of the despair that it evokes. For example, a young woman in one study (Rakfeldt, 1987) noted that because she was in hospital with an eating disorder her friends would accept her more than if she had been diagnosed as having schizophrenia. Another study subject (with the diagnosis of schizoaffective disorder) said almost desperately how important it was that he convince the hospital staff that he was depressed, not schizophrenic. He seemed driven to prove to himself and to others that he was not a 'nut' or a 'hopeless case'.

The contributions of treatment interventions to apathy and withdrawal may also be particularly powerful in schizophrenia. Some of the most common treatment efforts may inadvertently create the opposite effect from the ones intended. Patients with schizophrenia are often told that they have a disease like diabetes. They are told that they will have the disease all their lives, that it involves major and permanent functional impairment, and that they will have a life-long need for medication (Harding *et al*, 1987*b*).

One person participating in a workshop on schizophrenia for professionals, consumers, and family members reported that after having received this message she gave up her teaching career. A few years later, a friend advised her instead: 'Try to do a little something — little by little'. She took the advice and started working part-time. The patient, who was still psychotic, found that she was better able to control her psychosis while working. She then became more involved with the world, and began functioning more competently, finally returning to a teaching job. She had surmounted the withdrawal apparently fostered by the well-intended 'therapeutic' intervention.

Finally, the accumulation of undermining experiences may be particularly powerful in schizophrenia. Stigma, discouraging 'therapeutic' messages, social dysfunction, and the problems schizophrenia often generates in functioning cognitively may all interact over time to make remaining engaged, involved, and hopeful particularly difficult.

But could not experiences such as those described above be assumed to be adequately covered by some general term like 'demoralisation'? Perhaps, but such terms in psychological domains are often used as pseudo-explanations to note and de-emphasise the phenomenon in order to make way for detailed biological inquiry. This is similar to how the term 'constitutional factors' was used as a biological pseudo-explanation not so long ago to 'get that out of the way' so the 'really important' psychological features could be explored in detail. Both tendencies are unfortunate. Just as the various possible biological contributions to negative symptoms need to be explored in detail, so too the various psychological and social sources need to be clarified. Only through such a combined approach will be it possible to achieve optimal understanding and treatment.

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John S. Strauss, MD; Jaak Rakfeldt, PhD; Courtenay M. Harding, PhD; Paul Lieberman, MD, *Yale University School of Medicine, Department of Psychiatry, New Haven, Connecticut, USA*