Sawbones 429: Schizophrenia

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Intro (Clint McElroy): *Sawbones* is a show about medical history and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and not try to diagnose your mystery boil? We think you've earned it. Just sit back, relax, and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Hello, everybody, and welcome to *Sawbones*, a marital tour of misguided medicine. I'm your cohost, Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: Sorry. The microphone is, like, blocking— I moved the angle of it.

Sydnee: I'm sorry the—

Justin: So it'd be hanging upside down. Because I've seen people do that in movies where it's, like, I think they do it in *Airheads* when Joe Mantegna is, like, it's hanging upside down.

Sydnee: Yeah.

Justin: And I thought that looked cool.

Sydnee: I don't like that.

Justin: I don't like it either, but it feels like now, while you're recording with it, seems like the worst possible time to adjust microphone placement. It feels like it would be unpleasant.

Sydnee: Well, as long as we're addressing inconvenient things, I apologize for my gravelly, nasally, congested voice.

Justin: Yes, I believe you were yelling about how much you're sneezing and how sickness is a weakness just moments before we began recording.

Sydnee: That was not what I was saying. Don't say that! I was obviously joking.

Justin: Sickness is a weakness within yourself.

Sydnee: Within myself.

Justin: Others may get—

Sydnee: I was mad at myself for continuing to be sick, which, of course, is irrational and we should not feel guilt or shame at being ill, which is a state we cannot control, which you know about me. But when you just put that out there on a podcast, it makes it sound like secretly Sydnee—

Justin: No, it's not a secret. Sickness is your sworn enemy. You've spent your entire life fighting it. And the fact that it would sneak up on you when you weren't expecting it and get a sucker punch in sucks.

Sydnee: Ah, Justin those are— In the old days, see, in the early days of infectious disease fighting, that was the way that the doctor was poised as the defender against disease, protecting the patient. But nowadays...

Justin: [crosstalk] What are you now, are you guys partners?

Sydnee: ...the relationship between wellness and illness— No, it's all much more complicated. The concept of quality of life is such a bigger picture than sick or well or disease...

Justin: What about today's topic? Is it complicated?

Sydnee: Yes, it actually is very complicated. That wasn't why I was talking about that. I was more just...

Justin: Yeah, I know, but I was saying—

Sydnee: I was off on a tangent.

Justin: Yeah, I could feel the tangent and that specific tangent of yours, I've gone down that well quite a few times and we honestly just don't have the time for it.

Sydnee: I'm not on cold medicine. I know— And also, I don't have COVID. I feel like that's necessary to say, especially since we're clearly together. Well, I guess nobody can tell that we are together. I don't have COVID. We all just— Our kids brought home a cold. We all got tested. We don't have COVID. We just have a cold and it sucks, but I'll be fine. That's not what we're talking about. My dear friend John suggested this topic.

Justin: Okay.

Sydnee: Schizophrenia. We've never talked about it on the show before, and it is a big, complicated topic. And I will say that I wanted to kind of do an episode to dispel a couple of, I think, common misconceptions and just to give, like, an overview of what schizophrenia is and when did we start diagnosing it and what have— You could probably guess anything within the realm of mental illness when it comes to historical treatments, I mean, it's going to be bad.

Justin: Yes.

Sydnee: I mean, we've done the show long enough. If you've listened to past episodes, you know the kinds of horrible things we used to do. We always used to do horrible things in medicine, right? And even, you could argue, still now, we just don't know what they are yet. So we always did things in the name of healing that were bad. I think it is fair to say that when it comes to psychiatric illness, it was a— Maybe— I don't want to say it was worse than everything else, but I mean...

Justin: Especially bad.

Sydnee: Yes, especially since psychiatric illness can be so difficult even now, people don't fit well in boxes. And so to put people in boxes before boxes existed was incredibly difficult. And so anyone who was inconvenient could

be labeled as whatever and then subjected to all number of inhumane treatments. So anyway, I think that's always important to recognize before we start talking about the history of mental illness.

Justin: I will also say that as a layman here, I feel like schizophrenia is one of those disorders, like amnesia, that is narratively useful and so was like, co-opted in a lot of fiction as, like, this is a useful way of doing— This is a useful storytelling device. So I will implement it without a lot of knowledge of how it actually works or manifests, because at this point, nobody would have right? But, like, even you go as far back as like, this isn't exactly that, but Dr. Jekyll and Mr. Hyde is very much in that vein.

Sydnee: I mention that in this episode.

Justin: Yes! Okay, I'm going to shut up.

Sydnee: But that— Because it isn't schizophrenia, but that's exactly what—

Justin: Well, no, it's a potion, Sydnee, I know.

Sydnee: Well, I mean— Okay, that's a good place to start. So schizophrenia comes from the Greek for split and mind. Schizo-phrenia. Split mind. And so there's a lot of confusion because I think schizophrenia has been used in popular media for a long time as shorthand for what we used to call multiple personality disorder or dissociative identity disorder. DID is what it's known by now, and they are not the same thing.

But I think split mind, split personality— I can see where people got confused. And Jekyll and Hyde is exactly— People will say that, like, it's like schizophrenia. It's like Jekyll and Hyde. No, that's not what schizophrenia is at all. It's not even really what DID is. I mean... If we're talking about using a potion to turn into a monster, that's definitely not what DID is.

Justin: So you're saying that DID is not potion-based.

Sydnee: No, there's no potion involved in any of these. But even after the term had been coined, which really just dates back to the early 1900s, is when we get the word schizophrenia. We'll talk about kind of before that,

but after it had been used, there were still psychiatrists and psychologists making that mistake and using it interchangeably with what we now know is a distinct psychiatric diagnosis.

Justin: Right.

Sydnee: So it is not multiple personalities. That is not dissociative identity disorder. Schizophrenia is different. I think that's important to know. And yes, I know, split mind. It's not the same thing.

Justin: Okay.

Sydnee: Common misconception. People still get it wrong in movies, which is frustrating because you have Google now.

Justin: Yeah, you could just look it you could look it up.

Sydnee: I understand there was a time where this may have been more difficult to find out, where you had to know somebody in the psychiatric field and call them. Now we have Google.

Justin: One of your top results would also probably be here's 20 movies that got schizophrenia wrong. Here's exactly why.

Sydnee: Now, I didn't want to get— Because I wanted to kind of give a broad overview of schizophrenia, especially in the more modern times, and by modern, I mean, like, from when we first detailed accounts of it in the mid 1800s till now, we don't have accounts of what we would say, absolutely, 100% this is schizophrenia in the ancient world. That doesn't mean it didn't happen.

It's just that because it's a constellation of symptoms that we put together into a diagnosis and said when we see this combo of symptoms, we call it this? It's not as easy to look back historically and assume that people had it. We can guess, but you know what I mean? Like, people weren't—

We see very old diagnoses in the ancient world for things like melancholia, right? Or we see people who just had what they would have called like

insanity or madness or whatever, but we don't see specifically what we would call schizophrenia. There is one that comes close from Ibn Sina, who we've talked about before, who wrote during the Middle Ages about severe madness, which seems somewhat similar, but like it's still not quite schizophrenia. And we don't see exact accounts in, like, ancient Greek or Egyptian literature or anything like that.

Again, we would see mania, we would see other things, but not exactly what we call schizophrenia. I think, and John, who suggested this to me, pointed out we could probably go back and look at some of the accounts of the saints and things and find some probably examples of schizophrenia here and there. And certainly their academic papers.

You can read about that. I'm not going to get into all of those now. Those could be future episodes. This topic is broad enough to talk about lots of different things. Um, in the 19th century, psychiatrists and psychologists started writing up initially cases of what they thought were these unusual presentations of kind of a dementia. That's what they thought it was. It seemed— Because they were young people. So young people, and by young I mean, like, as young as 15, although classically, around 20 and up to 25, even up to 30. But in that sort of young adult age range, people presenting with what they thought initially was this kind of form of dementia.

They seem to lose the ability to function independently in a variety of ways. And they started writing up these descriptions and saying, like, we don't know what this exact unique form of what they were calling insanity is or dementia is, but it's something different. And again, I'm not saying that it didn't exist before then. This is just when they recognized it. It was Emil Kraepelin, who was a German psychiatrist who first wrote down what we called at the time dementia precox.

Justin: Okay.

Sydnee: And this reference, this sort of adolescent dementia is kind of what they thought of it as. Again, it is not dementia. We know this now.

Justin: Not dementia.

Sydnee: No. And he also laid out the different types of what we would eventually come to know as Schizophrenia. There was simple, there was hepophrenia, there was depressive, there was circular, agitated, periodic paranoia, catatonic, schizophagia. All of these are sort of precursors to the different—

You know, when we talk about schizophrenia now, it's a spectrum of disorders. It's not one thing. Which, again, is always true in psychiatry. I think it's fair to say. Justin, anxiety is not one thing. Right?

Justin: No. As I've discovered, there's a whole bevy of different flavors and delights awaiting you. Of every variety. I like to think I've sampled from a lot of the different bins in that particular pick-a-mix. But yeah, there's a lot of different ways it can manifest.

Sydnee: There are things we look for, like certain things that put you in that area of anxiety or depression or bipolar disorder or schizophrenia.

Justin: Well, it's because you—

Sydnee: But what you are within that area is unique to you.

Justin: Tell me this is wrong, but again, I'm a layman.

Sydnee: Okay.

Justin: To me, it seems like the mind is so incredibly complex that what we're basically doing is naming like, Crayola shades, right? It's like this is sort of the vibe of what this is. But, like, we honestly don't even know how this big chunk of meat even actually works, really. So we're just trying to come up with the best vocabulary that we can for dealing with it. And that's constantly evolving because our understanding of the mind is constantly evolving.

Sydnee: Well, and it's difficult too, because not to get too ahead of myself, but if we start getting into like neurotransmitters and receptors and what, on a biochemical level, on a neurochemical level, what is happening inside your brain? I don't know.

Justin: [whispers] We don't know.

Sydnee: I mean, not that it is unknowable. We can know things. We have done studies, we've learned things...

Justin: Yeah, it's probably magic. A lot of times we're sitting on the couch and, like, just watching *Survivor*, and Sydnee will lean over to me and she'll be like, "the brain, it's probably magic and none of us want to talk about it, but that's what's up."

Sydnee: I've never said that. I've never said that. No, I mean, from patient to patient. When I sit down with someone and we discuss a possible diagnosis of, say, depression, I am not going to do some sort of test on them, some sort of, like, chemical or blood test or draw any levels to prove that. I'm going to use diagnostic criteria that are laid out.

And if you meet certain symptom criteria in a certain duration and that it's causing dysfunction in your life, in certain areas, then I'm going to say, yes, that diagnosis fits you, but I'm not going to do some— You know? So I think it's harder. It's easier when I can just do a blood test and say, yep, your cholesterol is high. Here it is. I tested it. I see it. It's more difficult.

The idea behind the term and the description that Kraepelin came up with, and I think this is very— I don't think this is necessarily helpful, but it was well put.

Justin: [laughs] You say that to me all the time after I finish conversations, Sydnee.

Sydnee: He said that there are some people he thought that you had some sort of predisposition, that this was something that was sort of innate to you, which is interesting because he's sort of predicting the genetic predisposition, which we know there is with a lot of different illnesses, like... and psychiatric illnesses as well. You see this genetic predisposition.

But he felt that these individuals would, and this is his quote, "become wrecked on the cliffs of puberty." Actually, that is not from Kraepelin.

Kraepelin said they were predisposed. And it was Heinrich Schule who then said they were wrecked on the cliffs of puberty.

Justin: I was wrecked on the cliff of puberty. Who wasn't, man?

Sydnee: We were all wrecked on the cliffs of puberty.

Justin: Yeah, I don't want to meet somebody who wasn't wrecked on the cliffs of puberty.

Sydnee: Glasses and braces and acne all at the same time.

Justin: God, that's a good turn of phrase. If you walk away with nothing else from this episode, wrecked on the cliffs of puberty.

Sydnee: And then they developed this kind of dementia from this, it could become chronic. And these individuals were thought to not be able to really function in the sense that they couldn't do the things that modern society then required them to do, live independently, have a job, have a family, you know. Or maybe just as basic as, like, get themselves dressed and fed and cleaned and all the sort of activities of daily living.

It was based on lots of clinical observation. That's what Kraepelin did a ton of; watch people and write about them. There were no strict criteria at the time. He came up with these sort of loose bubbles to put people in. The more strict definitions would come later.

And basically, anybody with a cognitive deficit, you have executive dysfunction meaning like planning and deciding how to execute an action was a problem for you. And then this sort of terminal state could be put into this broad bucket that we were going to call schizophrenia. His thought was sort of like, we'll figure out the whys later and we'll be able to define it better, probably eventually, but for now, this is what I'm seeing.

Justin: "This is the best I got."

Sydnee: And there were a lot of, like, at the time, people who just kind of observed and wrote about it without making too many claims, which I guess is a good way to go about science.

Justin: Yeah.

Sydnee: Before you make too many claims, observe it and write it down. OK. It wouldn't be until 1908 when Bleuler, who was a Swiss psychiatrist, would actually call it schizophrenia. And again, it was from this concept of a split mind, but it wasn't because of multiple personalities or dissociative identities.

It was the split between the different aspects of your mind, your personality and your thinking and your memory and your perception. All of those things seem to be functioning independently of each other. So you would become sort of... Like, the way that he saw it is that people are becoming kind of removed from the reality around them. They were out of context.

So... and if you think about some of the symptoms of schizophrenia, some of the ones that we think about most prominently and especially are displayed, I think, in media when it comes to like, hallucinations, your perception is split from reality. You're hearing a voice that isn't actually there.

Justin: So, the split in the mind is less like two people in one mind and more the split between your external self and the world and your internal self and like a disconnect between those two.

Sydnee: Exactly. Exactly. Which, one of the phrases we use a lot when we talk about someone who is experiencing these symptoms is they are reacting to internal stimuli. I'll say that I can tell that this person is reacting to internal stimuli. That's one of the things we're trained to do is observe.

Like, I imagine you're having hallucinations right now because it seems like you're hearing things or seeing things that I am not experiencing. And that's exactly what it is. It's an internal and external sort of split. And this can also be split from how you react to things. How you feel about me in that moment may be split from the way you react to me in that moment.

If you are having a psychotic episode, even though you're my husband and you love me in that moment, we may have a very different interaction because your personality, your behaviors, the way you're perceiving me, it's all split from what we know of each other.

Justin: Okay.

Sydnee: Okay. And this is when we would really start to define the symptoms that we would call schizophrenia. So there's this base sort of split within your mind and then you could distinguish things like your affect might change. These are sort of what we thought about over time is like the negative symptoms, like this sort of flat affect, meaning you kind of looked like you are not— Like, unemotional, not reacting to anything.

Things like ambivalence, impaired association of ideas. Like you say— I say one thing and your answer to me has nothing to do with it because you're not really associating those ideas with anything. You know, that kind of thing. And then the things that we think of as positive symptoms meaning hallucinations or delusions and a delusion is just a fixed belief that is not true.

Justin: Okay.

Sydnee: Now, obviously, once we started defining this thing, this diagnosis, we decided we should find a way to treat it.

Justin: And that's where I'm assuming the wheels really fall off.

Sydnee: Of course, as always on this show. But before we do that, let's go to the billing department.

Justin: Let's go.

[theme music plays]

[ad break]

[Mad Fun ad]

Evelyn: Hello, dreamers. This is Evelyn Dinton, CEO of the only world class, fully immersive theme resort, Steeplechase. You know, I've been seeing more and more reports on the blogs that our beloved park simply isn't safe anymore.

Justin: Murdered them?

Travis: I'm going to wreck it.

Evelyn: They say they got mugged by brigands in the fantasy kingdom of Ephemera. Or hijacked by space pirates in Infinitum.

Griffin: I mean, I could have a knife.

Travis: My papa said that I needed to do a crime!

Evelyn: Friends, I'm here to reassure you that it's all part of the show. These criminals were really just overzealous staff trying to make things a little more magical for our guests. We're just as safe as we've always been. This isn't a a county fair, dreamers. This is Steeplechase.

Justin: The Adventure Zone. Every Thursday at MaximumFun.org.

[Max Fun ad]

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Justin: Alright, Syd, if I understand correctly, things are about to go not so great for schizophrenia treatment.

Sydnee: So it's the early 1900s. We've defined what schizophrenia is. We recognize it, and I'd say again, most prominently now, we associate it with hallucinations and delusions. Those are sort of the two, what we call, psychotic features. And that's another really important thing, I think, to note in this episode. That this isn't just about psychosis, although part of schizophrenia is this experience of what we call psychosis, and that means either auditory or visual hallucinations.

So you're seeing or hearing things that aren't actually present with you. Or... And delusions meaning these fixed ideas that aren't true. So, um... common ones are paranoid, sort of delusions. One that I hear a lot is, "the government is tracking me."

Justin: Mm-hmm.

Sydnee: They've put a chip in me. They're following me. Those people over there are secretly government agents. They're watching me, things like that. And they're fixed because I can't just tell you, "Oh, actually, that didn't happen."

Justin: "Oh, actually, you've misunderstood." Right.

Sydnee: Right. Okay. So... And I think that those are the ones that you see, again, most prominently displayed when people often incorrectly talk about schizophrenia and they don't talk about these other symptoms, which are more the sort of, like, not really responsive emotionally to things or not having the motivation to get up and do things or even moving into, like, the catatonic states. We're just sort of sitting motionless, not reacting to any stimuli.

All of these things can fall under schizophrenia, and there is, again, a whole spectrum of other related disorders, schizophreniform disorders. But the psychosis is not psychotic. And when you hear—

Justin: What?

Sydnee: It is psychotic, but it's not— Okay. When you hear the word psychotic or you hear somebody on a TV show say psychopath, what are they talking about?

Justin: Like, evil.

Sydnee: Right. They're saying evil. They're saying that there's someone who might...

Justin: Murder people. Like a serial killer.

Sydnee: Exactly. This is not true. This is not related. And this is really important to know when we're talking about schizophrenia and psychosis and schizophreniform things like schizoaffective disorder. All this stuff where people experience hallucinations and delusions, which is what they connect it to, these people are not they're not murdering people. There is no inherent risk of them murdering someone. That is not a psychopath.

A psychopath is experiencing these symptoms. What they are talking about, I believe, is someone with antisocial personality disorder, which doesn't mean you don't like hanging around people. That's not what antisocial means. And what I think the word they're searching for is sociopath. And that's a whole other psychiatric diagnosis that we still shouldn't stigmatize by saying hey, everybody with this diagnosis kills people. We should never say that.

But whenever they say psychopath in that context, again, a Google search would show them they're wrong and they're further stigmatizing a serious mental illness called schizophrenia or psychosis or other things. Bipolar disorder can sometimes manifest psychotic symptoms. That doesn't mean that— In fact, people with mental illness are far more likely to harm themselves than they are to harm other people.

And I just wanted to take a moment while discussing schizophrenia and psychotic symptoms to talk about that because it is so often used wrong, even today, when it is so easy to figure this stuff out. Now, just like now, back then, when you suffered from these sorts of disorders, from psychotic

symptoms, there were a lot of unhelpful, scary approaches to treatment. Part of that was probably you still had a lot of people who saw someone talking to someone who wasn't there and might assume something religious or spiritual was happening, some sort of demonic possession.

Justin: Right, yeah.

Sydnee: You know, I mean, there would still be people involved in scientific pursuits who were reacting off of sort of ingrained, incorrect magical beliefs, whether they realize that or not and back in the same time, any time you look into this time period, you have to remember that if we are moving from the early to mid 1900s, we're—

There are a lot of people involved in scientific pursuits, people you may think of as scientific heroes who were involved in eugenics. I know that this is sad to hear, but I have learned from studying medical history, if you hear about some great scientist or doctor from this period of history before you start talking about how great they are...

Justin: Just take a second. Don't put them on a coin. Don't name a building in their honor. Just take one second.

Sydnee: Just do a quick search to see if they were into eugenics, because a lot of them were.

Justin: You should just do that for everybody, really, just as a cursory thing. If you meet a new friend, just check that.

Sydnee: So because of this overlap of our understanding of schizophrenia on the rise and eugenics also on the rise, a lot of early efforts at, I suppose, treatment is the word they would have used. I would not say treatment now were mainly aimed at institutionalizing and sterilizing people with schizophrenia.

We didn't understand it. We understood these people needed more help, or else they would end up often, you know, unsheltered, starving, you know, because they had no means of— People with really severe disease, probably

could not maintain some sort of employment or if they didn't have family to care for them.

And at the time, it was also considered appropriate to take someone in your family who maybe you could take care of, who had a disorder like this and put them in an institution. That was what people did. I would argue that's not a good idea, and we shouldn't do that, but that is what people did.

Justin: Really laying down the law.

Sydnee: And their main concern was that this is an undesirable heritable condition. And there were lots of things—

Justin: Heri— Sorry, heritable?

Sydnee: You could inherit it. Genetic. And so we need to focus our efforts on putting them somewhere where they'll be safe and making sure they cannot reproduce, which, of course, is just as terrible as it sounds. In other parts of the world, as we move into the 1930s, you can imagine that in Nazi Germany, schizophrenia was on the list of things you could be killed for, because, again, there's this overlap.

There are people who actually had what we would call schizophrenia now. And then any psychiatric diagnosis like this was a useful bucket to put people you didn't want in society in.

Justin: Right, right.

Sydnee: And so we've seen this very classically with the LGBTQ community. We will diagnose you with something psych— Or we'll just call the fact that you're gay a psychiatric illness, and we will sterilize you or institutionalize you or, you know, impose these brutal treatments or even kill you so that society will not suffer from your disorder.

This was a— Schizophrenia was a popular diagnosis used by the Soviet Union to silence political dissidents. You would diagnose them with schizophrenia and have them institutionalized forever and you could make them disappear that way. Just diagnose them with schizophrenia. And this is

not to undermine how terrible it was for the people who also actually had schizophrenia.

A lot of the other attempts to treat it, so these were obviously, I would not call any of these treatments. These were just sort of the way people were handled when they had this diagnosis. A lot of the attempts to treat schizophrenia were similar to other psychiatric illnesses of the time. And we've done lots of episodes on these particular things.

Lobotomies were attempted. We've talked about prefrontal lobotomies a lot on the show. I think we've done a whole episode, yes, on just that. Schizophrenia is one of the diagnoses they would try that for because if you imagine someone with a disorganized form of schizophrenia, we might call it now, someone who had a lot of positive symptoms, who...

Justin: What does that mean?

Sydnee: Hallucinations, delusions, things that were very—

Justin: Positive— Wait, what does positive symptoms mean?

Sydnee: Okay. Positive and negative symptoms. Positive symptoms are things you see that are actions, active symptoms. You can tell— If someone is having a hallucination, a lot of times, especially if you engage with them, you can tell. That's something you could see or observe or talk to them about. A negative symptom is something that it's like the absence of stuff.

Justin: Oh, okay. Makes sense.

Sydnee: Somebody sitting there quietly, not reacting to you.

Justin: Okay.

Sydnee: So a flat affect would be a negative symptom.

Justin: Okay.

Sydnee: So when it comes to somebody who's like, a disorganized— What we would think of as disorganized, somebody who has a lot of trouble with, like, remembering personal hygiene. A lot of people that I take care of could probably— And I am not a psychiatrist. I'm a family doctor. I have a lot of extra experience and training in behavioral medicine. And again, I'm not a psychiatrist, but a lot of extra work in psychiatry.

I work very closely with a lot of psychiatrists and psychologists in the work that I do. And when you think about somebody who is experiencing homelessness, who seems to be disconnected completely from, like, you try to engage with them and they're talking to people who aren't there, it looks like they have not been able to bathe or clean. You may— This is sort of what you might think of as somebody who's suffering from disorganized schizophrenia.

Justin: Okay.

Sydnee: So you can see how specifically those patients would have been stigmatized and maligned by society. So lobotomies would make you calmer was the thought. And so they were aimed at people, especially experiencing those symptoms. People might be subjected to insulin coma therapy.

Justin: Mm. What's that?

Sydnee: If you give somebody insulin and make their sugar drop super low, and this is true if your sugar ever— If you're on insulin for your diabetes and you don't eat or you take too much insulin, whatever, and your sugar drops very low, you can have a seizure and go into a coma. And it was thought that this sort of reset the brain in some way and would fix the schizophrenic symptoms if you made them have seizures or go into a coma that way.

So you would do— And obviously, you could kill people or do other damage from this. But this was a treatment that was attempted. There was something called Metrosal Shock Therapy, which was— Metrosal was a powerful CNS stimulant, CNS, like, central nervous system stimulant that you could give.

So instead of insulin, give them this powerful stimulant that, again, would induce seizures and was thought to reset the brain. And eventually, these were the precursors to electrocompulsive therapy, ECT, which does have applications today, legit, but back then was just sort of this cure-all that we used for anything that we didn't know what else to do with.

Obviously, these are all incredibly dangerous, and there were a lot of people who were killed this way. It wasn't until the mid-1900s that we started to find medications that really help schizophrenia. In 1952, there was a French surgeon who was trying to find ways to reduce shock that could occur in surgery. Like blood pressure dropping shock. He thought antihistamines might help. He was experimenting with one called Chlorpromazine and he noticed that it also had this really powerful psychiatric effect as well.

And so it was kind of an accident, but some psychiatrists started trying chlorpromazine on their schizophrenic patients. Again, it was mainly just a way of sort of sedating and calming people is what they were looking for. But they did notice improvement and it was the first medication that had shown any improvement whatsoever for patients with schizophrenia. So the first generation of antipsychotics were sort of these Thorazine, these like similar derivatives.

And all of these initial medications, and that's kind of how we class them, now, the first generation and second generation antipsychotics. The second generation is sometimes called the atypicals. Typicals and atypicals. The typicals, or the first generation, all had similar issues. They had side effects that were they would induce this sort of Parkinson's-like syndrome. EPS, extrapyramidal side effects or syndrome often is what it's called.

But you'd get this sort of shuffling gait, something called Tardive Dyskinesia, which means these uncontrollable mouth movements could result. And a lot of these things weren't reversible.

Justin: I bet you've seen depictions of these so many times in media.

Sydnee: Yes, yes, I remember being taught in med school that you will see patients in... I'm not excusing this. This is what someone said to me. In psychiatric facilities doing what they would call the Thorazine shuffle. And

they were referencing that side effect that people would suffer from taking these medications. The risk was like 5% per year of exposure.

Justin: Okay.

Sydnee: And if you were going to be on these medications long term...

Justin: That's pretty high.

Sydnee: It's very high.

Justin: I mean, 5% doesn't sound great if you're... I was going to say playing the lottery, but I don't know, 5% I might take a whirl.

Sydnee: Yeah, if you had a 5% chance, you probably would. Anyway, but then they came up with meds for Parkinson's, of course. So they would give the give people these medications like, well, it worked for Parkinson's, what would work for this? And they could but then those medicines had side effects too. So we were sort of again, we were just putting all these medications into people and they weren't ideal. It's not like we were completely giving people back their lives with these medications.

Justin: Right. It seems like a lot of therapies that these start out at are trying to get people to— It's more, how do we get this person to blend in better with us? Like, how do we make this less uncomfortable for us?

Sydnee: For us.

Justin: Right. Like, how... Yeah. Right?

Sydnee: [sighs] And what you just hit on is what, you know, not to get too far off on a side tangent, but because of, not just schizophrenia and the way we treated schizophrenia, but a lot of psychiatric disorders like this, you saw this rise in this antipsychiatry movement, which the idea that all dysfunction isn't inherent to you as a person.

It's society that's dysfunctional. And your inability to fit into a dysfunctional society does not make you dysfunctional. It just is a marker of how

dysfunctional our society is. I do not believe that, obviously, I believe there is real psychiatric illness. I know that because I went to medical school and we have science that tells us. I mean, Justin, I love you, our brains are different. I don't experience anxiety like you do.

Justin: No.

Sydnee: I couldn't just try and do that. I couldn't will it in and you couldn't will it away. So obviously there is psychiatric illness. But I think that they do raise an important point, which is sometimes our treatments can be aimed at exactly what you just said, making us less uncomfortable, as opposed to helping someone who is ill experience the best quality of life that they can.

Justin: Right.

Sydnee: So I think, even though I do not agree with that movement, there is an important lesson in what you said. A note of caution. The second generation antipsychotics had less risk of these side effects. There were other risks. Like, one thing that we think about a lot is these risks of these medications can affect your metabolism. And we can see people who are long term on second generation antipsychotics are at higher risk for things like heart disease or strokes. And so again, and these are patients who are already at higher risk for these diseases because they tend to not get regular preventive healthcare because their disease prevents them from that.

So we see that problem too. There was a medication that came out, clozapine, which seemed to not have any of these side effects and was a lot better for people. However, it can make your white blood cells go really low. So anyway, my point is we have lots of medications, there are lots of things that have been helpful when it comes to treating schizophrenia, but we don't have that magic medicine that fixes anything right now. We just don't.

We have lots of ways of managing schizophrenia. Patients with schizophrenia, and I have taken care of many, can be on medications that help them live happy, quality lives and can be functionally independent, completely. It's just difficult. And it's especially difficult because it is so stigmatizing of a diagnosis, because exactly what you said. When you see

someone reacting to internal stimuli, I think a lot of people still have that sort of, um, I think it's probably rooted in our society and in some magical thinking and some probably religious root that it scares you.

Justin: It scares you because what, I'm really talking out my butt here, I don't want to get too, like, college freshman Philosophy 101, but I think that we— To us, the way minds function is sort of essential to personhood. And I've seen this a lot of times just in, like, mental health conversations that I've been a part of where we don't really know how to draw a dividing line between accountability and mental illness.

And I think there's definitely, you see it in this time period, we tend to think of something that makes a human being is a properly functioning mind. Because otherwise how do I communicate with you? I don't know, I don't understand how your mind works. We rob people whose brains don't work the same way as ours of their humanness.

Sydnee: Yes.

Justin: They are othered. And I mean, you see this, this is not a new phenomenon, obviously, but I think especially when you're talking about, "I'm saying things to you and I don't understand how your brain is interpreting the things that I'm saying." I think for a lot of people it becomes easier to just say, "Well, that's not a person anymore. That is an illness that I don't understand."

You know what I mean? And I think the best thing we can do... That's why I think the repeated continuing attempts to normalize mental illness are so important because eventually you start to realize that it is a wide variety. Like a lot of people have different ways their brains work and it doesn't rob them of their personhood.

Sydnee: And exactly what you're saying is the only way we move forward, not just socially, with providing better structures for people who have things like schizophrenia. Because in order to appropriately treat people, we need a lot more social support. We need a lot more not just the medicines, not just the psychiatric care, not just the therapy, but support for people who do have extra needs when it comes to living independently, who do need more

help with life skills or job skills, or ensuring hygiene or nutrition or socialization. All of those things, you know, society should be helping with. And the other driver of that is research.

We still so poorly understand all this. We know that dopamine plays a role. We know that there's maybe some sort of neurodegenerative process, meaning that if you can treat people well when they have that first episode or even catch it before, catch it— There's a prodrome, there's some symptoms that can tell you somebody might be about to have a psychotic episode. If you can treat people early, there's some evidence that you can prevent further sort of degeneration and seeing the disease worsened. We don't understand all that yet.

And the only way we understand that is if we put money and effort and thought into research and into treating these people as people who deserve, you know, evidence based scientific approaches to their care and then humane soci— you know, social approaches to the support for that care. Which that's a tall order.

Justin: Yeah.

Sydnee: Especially in a medical system where you are not incentivized to do anything that doesn't have an obvious financial benefit.

Justin: My gosh, I did not expect this twist in *Sawbones* that Sydnee at the end of this episode would have, wait a minute, problems with how the medical system works in this country?

Sydnee: I think the take home is when you hear— I mean, obviously you can't shout at your TV— Well, you can shout at your TV if you want. It just doesn't do any good. I mean, because I was going to say in the media, when schizophrenia is misrepresented, when people are called psychopaths because they murdered someone, which the two are not the same...

Justin: No. You know what you should call people who murder someone? Murderers.

Sydnee: Yeah, let's just do that. How about we don't assume a psychiatric diagnosis?

Justin: Wouldn't that be wild? Wouldn't that be wild? If you're watching a TV show, they like, turn the monitor out. It's like, "Folks, I think we've got a murderer on our hands." It's like, "Well, yeah, he murdered people. Yeah." It's like, "It's a murderer that we got again."

Sydnee: Well, because it's important that you're vigilant and aware of these things because it's how conversations about gun control turn into conversations about mental illness, which is tricky, because I'm all for more society focus on helping people with mental illness, on destigmatizing mental illness, on providing more affordable access to therapy and treatment and medicines. That has nothing to do with murderers.

Justin: Right. Just, yeah.

Sydnee: These are two separate conversations.

Justin: And it's interesting because I feel like even that conversation is an offshoot of the idea of trying to distance things from evil, right? So, like, we're not talking about evil anymore. There are these, like, mental illnesses that, like, can prompt people in this behavior. And it's like, "Well, this is good. We fixed it." It's like, well, but not everybody, y'all!

Sydnee: No.

Justin: Like, calm down.

Sydnee: No. Because the majority of people with schizophrenia or any other mental illness are much more likely, because of the way society will treat them, because of their lack of access to care, to engage in self-harm, than to ever harm anyone else. So you can dispel those myths and correct people when they don't know what schizophrenia is or what psychopathy is.

Justin: There you go. Thank you so much for listening to our show. We hope you have learned a little something today. Enjoyed yourself, maybe. McElroyMerch.com is the website for, uh, well, merchandise. I mean, you

almost certainly gathered that. And we recently had to cancel some tour dates in San Jose because my brother Travis got the COVID, but we are working to reschedule those right now.

We have also got some shows in November. We're going to be, at the 10th, in Cincinnati, November 11th in Detroit, November 12th in DC. And those are all *MBMBaM* shows and— *My Brother, My Brother, and Me*. And then November 13th, we're going to be doing *The Adventure Zone* in Washington, DC. If you go to McElroy.family, you can get tickets. Full vaccination or negative COVID test within 72 hours of the event start is required to attend. Masks are required unless actively eating or drinking!

So we hope you'll come out for those. Oh, thanks to Taxpayers for the use of their song *Medicines* as the intro and out of our program. And thanks to you for listening! That’s going to do it for us. Until next time. My name is Justin McElroy

Sydnee: And I'm Sydnee McElroy.

Justin: As always, don't drill a hole in your head.

[theme music plays]