Expecting the Broken Brain to Do Mental Pushups:
A Personal Journey
to Understanding Schizophrenia and Depression
Dave Elder

Sample Interview Questions

1. What does the title of the book mean?

It refers to the dynamic that played out in my family regarding my mother. You don't expect someone with a broken arm to do push-ups, but the family and friends of those with broken brains may routinely expect them to do the mental equivalent of that, and then judge them harshly for failing to perform. The added stress only makes the situation worse for the person with the broken brain, especially at times when they truly need concern and sympathy.

You wouldn't tell someone with a broken arm to just *snap out of it* because you know that no amount of *tough love* will help that person to do push-ups, but people who don't comprehend the genuinely broken nature of a family member or friend with schizophrenia, clinical depression or bipolar disorder, might believe that this tactic could work on them. My family basically treated my mother as if she was a *bad girl*, an unruly child, as if being schizophrenic was a choice she made — she could be *good and normal*, or she could be *bad and crazy*, and due to some flaw in her character, she chose to be *bad and crazy*. Perhaps if you spanked her in the right way, by, say, threatening her with a visit to the State Hospital and some shock treatments, maybe she'd be *good and normal*. If she chose to be *really bad*, going *off the deep end*, hearing those voices that made her do and say strange things, then you'd make good on that threat — you'd take her to the State Hospital where she'd get those shock treatments. You always knew from the look in her eyes when you mentioned the words *shock treatment* that whatever it might be in reality, it felt like a spanking to her, and one she really didn't want.

We think of people as having control over their brains, as most of us do, but someone in an episode of schizophrenia or clinical depression does <u>not</u> control their brain — their brain controls them. That's a simple turn of phrase, but what it means in the real world can take a long time to understand. In my case, it took over four decades, although to be fair to my younger self, for most of that time I didn't really focus much on figuring it out.

I also aim the title directly at the stigma that has in the past all too often attached itself to a psychiatric diagnosis. No one judges a person with a broken arm too harshly, even if that person got the broken arm by doing something foolish, such as choosing to ski down a slope that was more challenging than the skier's ability to handle. A broken arm is a broken arm — you see it for what it is, and you don't ask why the broken arm person can't do push-ups, because you know why. If you have to ask the question, you're a fool for not understanding the obvious circumstance.

A broken brain is no less broken, but it can't be seen the way a broken arm can, and it won't show up on an x-ray either. Alas, despite all the wonderful advances in modern medicine, no accurate methods exist for measuring the broken brain. A doctor can conclude that a deficiency in serotonin, dopamine and/or norepinephrine is causing a clinical depression, but he/she has no way with current technology to measure that deficiency. Still, the pain someone feels from a broken brain is just as real as from a broken arm, and the sufferer is just as much in need of relief from that suffering, if not more so.

The title is also part confession, and part penance. I was just as guilty as anyone of judging those with broken brains too harshly, and having grown up with a schizophrenic mother, I should have known better. I confess that I was guilty of this unreal expectation, because I didn't see the broken brain clearly, but now that I do, I want to make up for my mistakes by trying to help other people see it as well.

2. Why write a whole book about schizophrenia and depression?

I want to offer other people an easier way to get to some essential insights that I've had to learn the hard way. Through a book I can share my own experiences and misconceptions in the hope that my story can point others in the right direction.

Due to my life circumstances, at one point I found myself in the role of caregiver for someone with schizophrenia and someone with depression. In both cases, my initial attempts to handle the problem felt like trying to reach up and grab onto a large cloud in the sky. In the first case, my mother started hearing voices when I was only three and a half, and I felt like I'd been trying to understand her for most of my life, although between the time I left home for college and the moment my father died, I didn't focus on it the way

I had growing up and living in a house with her, or the way I would when I had to become more directly involved in her care following my father's death.

In each case, when I finally reached the point of grasping the essence of the condition, I felt as if I had just bent down and picked up a small rubber ball, one labeled *schizophrenia* and the other labeled *depression*. Those two points happened a few years apart, each as the result of events that I detail in the book, but in both cases I felt that while I had searched the sky in vain for clues to a huge and far-reaching mystery, the small simple answer had been sitting there at my feet all along.

3. Are schizophrenia and clinical depression actually very simple?

The basics of schizophrenia, clinical depression and bipolar disorder can be quite simple, particularly the parts that caregivers need to know. However, I don't want to make it sound as if I'm saying psychiatry is easy, because I know for a fact that it's not — some very smart people have spent their lives studying mental issues, and there's still a lot to discover. When you don't know much about psychiatry, you might question how much the professionals themselves know, but when you start to learn some of what they know, then you have a lot more respect for the depth of their knowledge and experience.

In both of my caregiver situations I knew the diagnosis — *disorganized schizophrenia* in the one, *clinical depression* in the other — and over time I learned how correct each diagnosis was. I have no way to judge how much knowledge and experience it took to make the initial diagnosis, but my guess is that both cases may well have required a significant amount of focused intelligence to make the correct call.

The good news for the caregiver is that someone in that role does not need to know even a fraction of what the professionals know. As long as the caregiver *gets* the basics of the situation, and then follows the psychiatrist's advice, he/she will have a clear grasp of how best to help the person in their care. Once those basics are understood, the psychiatrist's advice will also make a lot more sense.

4. What are the basics of schizophrenia and depression?

Schizophrenia, depression and bipolar disorder can all result from improper functioning of brain chemistry, which can occur as a result of genetic predispositions and some form of psychological and/or physical trauma. Referring to the person in my care during an episode of clinical depression, her psychiatrist said, "At the moment, her genetics are failing her."

When, as a caregiver, I had my first encounter with clinical depression, I made the usual mistake of trying to find some cause for it, as I detail in chapter 12, *Can Staten Island Cause Depression?* Was it the new neighborhood? The new apartment? The unfamiliar surroundings? Was it living with me? What had caused the sudden change in mood? The answer turned out to be much simpler than that — a major change in body chemistry had also caused a major change in brain chemistry, as I later learned.

When I finally saw the chemical nature of her clinical depression, at *The Sock Drawer Moment* that I detail in chapter 14, then I realized that it had little to do with her circumstances or surroundings. A king in a castle and a beggar on the street would both feel the same way if they had the brain chemical deficiency that caused her clinical depression. While my own genetic code is of course quite similar to that of my mother and my older brother, my genetics did not give me the kind of brain chemistry problems that each of them had. I can't take credit for that, or feel that I have a better character than either of them, or more intelligence — in the genetic lottery, I simply got a better, and luckier, hand. In the infinite variety of the human species, a certain percentage of people will get dealt a genetic hand that spells out *possible schizophrenia* of one type or another, and a certain percentage will pick up the genetic hand that spells *possible clinical depression* or *possible bipolar disorder*. The rest of us shouldn't feel or think ourselves better than them — we're simply luckier.

I wouldn't have said so in 1994, and as I mention in chapter 11 of the book, I had little sympathy for Kurt Cobain's troubles at the time. I could only wish to be as lucky as him, at the top of his game in his musical career, with a beautiful wife and a newborn child as well. It was many years after he took his own life until, at *The Sock Drawer Moment*, when his story touched mine in a small but very particular way, I realized that I was the lucky one, not him.

5. You mention bipolar disorder, but it's not in the subtitle of your book — what's the connection with schizophrenia and depression?

The best way to see the connection between bipolar disorder and clinical depression is to understand that clinical depression also sometimes goes by the name *unipolar disorder*. Simply put, clinical depression is the down pole of bipolar disorder. Someone with bipolar disorder, on that down side, feels essentially the same as someone with clinical depression because that person has a similar neurotransmitter deficiency. The difference comes from the other pole that the bipolar folks will swing to — people with bipolar disorder generally have a sine-wave type of cycle, alternating between a neurotransmitter deficiency similar to clinical depression, and a neurotransmitter *surplus*, sometimes feeling *down and under* but sometimes feeling *up and on top*. If you've seen and understood someone with clinical depression, then you know and understand what someone will look like on the low end of bipolar disorder, and you'll have a basic idea of what the polar opposite might look like as well. People with bipolar disorder also, on the rising and falling sides of the sine curve, can spend some time in the mid-range, feeling as normal as the rest of us.

6. Do you think people generally misunderstand the essential nature of schizophrenia and depression?

I know they do. I have over the years heard a number of comments from otherwise well-informed media personalities who, when venturing into this area, where they lack expertise, have said things that frankly surprised and disappointed me.

Part of the mix-up over neurotransmitter imbalances might stem from a blur between the meanings of *psychiatry* and *psychology*. At some point during my high school years, speaking with an adult — I don't now remember who — about my mother, the adult mentioned that Mom's main problem was psychiatric, not psychological, and asked if I understood what that meant. I don't remember now if the adult who asked was a teacher, but I answered that question the way I answered a lot of school questions — I knew the *expected* answer, so I said that my mother's problem was psychiatric, which meant that she had a physical problem with her brain, not a psychological one, but what that actually meant eluded me at the time, though I didn't say so, and I don't think I even quite realized the extent of my own confusion.

Growing up with my mother, I looked for psychological explanations for her behavior, and in so doing couldn't make any sense out of it. Part of the puzzle might stem from the fact that psychiatric conditions can have a psychological trigger that sets them off, leading family and friends to try to explain the bad psychiatric outcome in terms of the psychological stress that caused it. In my family's case, my mother, though she had her share of issues, didn't go *off the deep end* and start hearing voices until after the stress caused by the birth of my younger brother. We the family didn't clearly understand that following the onset of schizophrenia, my mother would never return to the person she had been before that episode, and probably couldn't return to that person.

7. What are the major themes of the book?

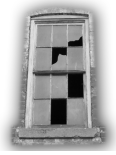
- The extent to which the family and friends of those suffering from various psychiatric conditions can misunderstand them, and as a result, can treat them badly without meaning to do so;

- The confusion between psychiatry and psychology, and the way that psychological stress can trigger a psychiatric condition;

- The stigma commonly attached to a psychiatric diagnosis;

- The psychiatric and/or psychological needs that underlie and cause a large majority of cases of alcoholism and drug addiction;

- The inclination of political leaders to dismiss, and subsequently defund, mental illness treatment and research facilities, which can create significant negative consequences for the affected communities.



8. Did you write this book primarily for caregivers of people with schizophrenia, depression and bipolar disorder?

Those are the people I really hope this book can help, because, having been in that role myself, I have to say that caregivers are the ones most in need of understanding. The sooner you get a handle on the basics about that broken brain person next to you, the sooner you'll have an idea of how best to care for them.

I do have another, larger audience in mind for the book as well, though — everyone else. I would like to see the book become part of a larger discussion about schizophrenia, depression and bipolar disorder. Even people who don't have any personal connection with these issues can benefit from a greater and more sympathetic understanding of them, and I think that a greater level of comprehension around mental difficulties will benefit our culture as a whole. Greater insight into other people's suffering can make you better appreciate your own good fortune and lead to more informed decisions about how best to bring aid to those in need.

All too frequently, when politicians look to cut spending, they put mental health funding on the chopping block. If more people correctly recognize the urgent need for this funding, and the benefit to our society that such funding provides, then they might not want to see their political leaders inclined to sacrifice something this important.

For more information about the book: www.mentalpushups.com
For media inquiries: Dave Elder, dave@mentalpushups.com
347-232-1082