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Exploring the Paradox of Terror Management Theory (TMT) in Individuals with Schizophrenia: A Theoretical Perspective

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Abstract

On the basis that terror management theory posits that death-related anxiety is buffered as a function of forming secure social bonds regardless of culture (Rosenblatt et al., 1989), all humans are motivated to decrease their existential vulnerability of fear of death and death-related issues, by seeking out social inclusion. This paper will explore why this may not hold true for individuals with schizophrenia, given the nature of our own social matrix in which this paradox lies. I also hope to bring to awareness that there are deep-rooted issues in need of greater attention.

Key words: terror management theory; schizophrenia; social isolation; paradox; death-related anxiety; in-group protection

Conception of Topic, Terror Management Theory (TMT) and the Paradox

As I read some of Nietzsche's works regarding death, I pondered on the inevitability of this aspect of life. I thought of my own demise, those of my friend's and family and of my pets. The experience wasn't pleasant, and I felt that little twinge of anxiety that accompanies thoughts of caskets, funerals, the sickly smell of flowers and the ultimate ride to the graveyard. I found myself drifting in and out of the adamant position of 'Okay… but I still have some time, and when the time comes someone will be with me'; but who knows who will be there… – maybe no one. Not wanting to think any more about myself, I turned to the population of my research-folks with schizophrenia – and this is where I conceptualized the topic of this paper.

It occurred to me that perhaps this vulnerable population also thinks about their own demise, and I began to wonder whether these folks experience death-related anxiety in an even greater and more profound way. I found that one early study (Feifel & Hermann, 1973) revealed that individuals with schizophrenia are inclined to experience more existential fear about death than those without schizophrenia; and Öztürk et al. (2021) have also demonstrated that death anxiety is greater in folks with schizophrenia. It would seem logical, then, to put in extra effort to connect with others in order to protect and buffer the anxiety of death-related fears, given the delicate nature of their emotional and psychological states. The question is, how do we address this issue as a society, when the very nature of our social matrix is what keeps these folks at the periphery of social inclusion in their greatest time of need, and prevents them from seeking out the necessary social bonds that would ensure protection from death-related anxiety?

Purpose of the Paper

The area of death anxiety in folks without psychiatric disorders is difficult enough to study, but the challenge truly arises when conceptualizing this theoretical construct within the schizophrenic community. The purpose of this paper is to explore why TMT – a well-established theory that includes basically everyone, regardless of psychological/emotional issues – does not seem to apply to a small percentage of folks with schizophrenia, and not necessarily when in active psychosis.

Some prior works have attempted to normalize the disorder; for example, Sullivan (1954) stated that individuals with schizophrenia are 'no different than anyone else', and in my own research regarding issues of self-esteem (Frank, 2009), I have sought to bring awareness to the notion that seeing the world differently does not make people with schizophrenia different, so TMT should hold up for them as well. However, I believe that the situation is more dire than the research suggests.

What This Paper Will Not Address

This paper is presented from a theoretical perspective by utilizing numerous resources that, by today's standards, are considered 'outdated'; however, the information provided by these early works are nonetheless important and useful. This paper is not intended to present or explore such concepts as cultural conformity, alienation of self, schizophrenia from an illness perspective (e.g. delusions and hallucinations), the nature of psychosis, death-anxiety as an alternate form of consciousness or, amongst many other positions, the etiology of schizophrenia. This paper in no way attempts to place fault in what may be society's way of degrading or dehumanizing these folks; however, in exploring the role of social bonds, social interactions etc., one can clearly read between the lines.

To avoid any confusion, it is understood that an individual with schizophrenia can move in and out of psychotic experiences, and when ongoing this can impair social interactions as well as interfere with everyday cognition. Any deficits discussed in this paper are not considered permanent features of schizophrenia but only as a possible side-effect of entering a specific cognitive state. Therefore, this paper is not an essay on the applicability or understanding of TMT to those individuals experiencing psychotic episodes. I do not seek to provide an explanation of the function or relevance of TMT before, during, after and as a result of psychotic experiences. I simply address the theory as it applies, or does not apply, to individuals with schizophrenia.

It came to my attention that some readers may ponder the notion that psychotic behavior may be thought of as a form of defense when considered within the TMT context. However, any form of psychoanalytic thought remains out of the scope of this paper. Within TMT those individual folks who are low on cultural conformity may be (or perhaps not) less successful in how they have developed their psychological defenses, given the stigma associated with a 'diagnosis'. However, aside from remaining out of the scope of this paper, this position does not add to our understanding of schizophrenia, death-related anxiety and TMT.

There is one major point that I want to bring to the reader's attention. I am fully aware that in critical psychology and anti/post-psychiatry circles, diagnostic categories remain controversial. I, for one, am supportive of Mary Boyle and her provocative yet ground-breaking works (1993, 2002) that not only define my own position, but those of many humanistic psychologists who truly believe that present-day psychiatry is nothing more than a trickle-down effect of big pharma. Therefore, my use of the terms people 'with schizophrenia', people 'diagnosed with schizophrenia', 'people who have schizophrenia' – all are descriptive labels, and are used for convenience to connote a collection of symptoms. It should be clear that I do not accept 'schizophrenia' to be a legitimate medical diagnostic category as generally proposed in the current literature.

Critical Theory

It is worth mentioning the role of critical theory as one of the underlying and elemental theories

that drive the assumptions of this paper. I can think of no better way to present them than through Horkheimer's position in which he states that

> Psychology no longer has to do with human beings as such. Rather, it must differentiate within each epoch the total spiritual powers available within individuals – the strivings at the root of their physical and intellectual efforts, and the spiritual factors that enrich the social and individual life process – from those relatively static psychic characteristics of individuals, groups, classes, races, and nations that are determined by the overall social structure: in short, from their character. (Horkheimer, 1932/1993, p. 119)

I include this statement because of its relevance as connected to my discussion reflecting my position that as a society, we need to address mortality salience in folks with schizophrenia in more progressive ways; yet we can never achieve this goal if we do not accept that our society, as a whole, is ill and damaged and in need of drastic changes.

Ernest Becker

American cultural anthropologist Ernest Becker explored the delicate nature of society's attempt at denying the inevitability of death. In his monumental but very much ignored work *The Denial of Death* (1973), Becker clearly lays out the hypothesis from which Greenberg, Pyszczynski and Solomon's position on death-related anxiety took shape in the form of TMT. Becker provided a clear yet disturbing message, stating that 'The irony of man's condition is that the deepest need is to be free of the anxiety of death and annihilation; but it is life itself which awakens it, and so we must shrink from being fully alive' (p. 66). Becker created a platform from which to begin to understand mortality salience; that is, how we contemplate the inevitability of our own death as the impetus for controlling our psychological processes and behaviors. I have taken Becker's founding perspective and expanded my thoughts within the context of TMT and folks with schizophrenia.

Terror Management Theory

Terror Management Theory is a theory that addresses our vulnerability to the existential fear of death (Greenberg et al., 1986). TMT proposes that motivation is implicit to human existence; it is the impetus that drives us to seek out others to better our chances of extending our mortality. Although death itself is uncontrollable, and the idea is, at the least, uncomfortable, many keep it at a psychological distance by allowing it to be nothing more than a fleeting thought. But whether we want to admit to it or not, the thought of death, as is death itself, is inescapable, and resides in the depths and recesses of our psyche, no matter our age, gender, ethnicity and culture (Rosenblatt et al., 1989), or even psychological health.

Our motivation to succeed at avoiding death, then, is both a conscious and an unconscious process (Becker, 1973; Mruk, 2006). Death-related fears can arise as a function of our personal understanding of what death is (Leary, 2004) as well as from within our own culture (Becker, 1973). Every culture has its own idea of what death means and what it represents, but the struggle to maintain our existence is, in a sense, universal (Rosenblatt et al., 1989): everyone is motivated to seek out ways that best increase their chances of survival. Survival mechanisms and individual approaches chosen to prolong or extend life are quite personal on both the psychological level and in social realms.

TMT suggests that we tend to seek out others who would help us in our plight to prolong our chances of survival, especially within a social context. However, for a small population of humanity, such as those with schizophrenia, the contradiction lies in those individuals who are most in need of security and protection least receiving it, and seeming to find more comfort and protection in isolation. Becker's early work (1973) suggested that when the intellectual human becomes aware of both his or her mortality and, even more so, their susceptibility to death, the possibility of a terrifying situation is created. To manage this terror, the overall standards of the culture in which the individual resides must be met or exceeded (Rosenblatt et

al. 1989). Meeting any type of social standard is a difficult task for anyone. In the case of individuals with severe psychiatric illnesses, cognitive and social challenges make the likelihood of meeting social and cultural standards, to the point of social inclusion, highly improbable. Theoretically, this improbability increases the susceptibility of succumbing to death; where there is minimal social attraction, there is marginal social protection.

Schizophrenia and the Challenge of Forming Social Bonds

The likelihood of forming strong social bonds increases if the individual has a strong sense of self, therefore high self-esteem leads to greater social inclusion. Pyszczynski et al. (2004) have suggested that having a robust sense of self-worth is not only beneficial in reducing one's own fear of death but is advantageous to survival, as the possibility of death is minimized through social inclusion (Mruk, 2006). From a logical perspective, forming social bonds, or at least having a network of individuals to turn to, would seem to be a priority in minimizing those fears. Many individuals seek to form social bonds, either within their family unit, by getting along with friends, and/or in developing extended social networks (i.e. co-workers, sports buddies and so on). These connections bring about a sense of emotional security, simply in knowing that if their mortality is in any way threatened, the option of turning to those they can trust creates a sense of peace akin to an emotional back-up for the soul.

It seems reasonable, then, that social inclusion is conducive to lessening the fear of death, as TMT suggests. It is also highly probable that if youth is a positive factor in increasing mortality and survival, then young individuals with severe mental illness should, in theory, develop greater resiliency to death-related anxiety as they have more time to cultivate social relationships. This begs the question of how older individuals with severe psychiatric illnesses fare as the prospect of death gets nearer.

One key to forming social bonds is the concept of 'likeability' (Mruk, 2006). Leary and Baumeister (2000) have outlined social attributes that society values. 'Being liked' is one of the main contributing factors for social inclusion, as '…people tend to exclude individuals who are not likeable or are otherwise socially undesirable interactants' (ibid., p. 17). Being liked by others helps to ensure that the individual is valued within their immediate social matrix such as their community.

The second attribute is that of social competence; group members are drawn to those individuals who can provide services that strengthen the integrity of the group. Because social competence is not characteristic of those with severe mental illness (Brune et al., 2007), the probability of providing useful services in becoming a viable member of the group as well as maintain group membership is minimized.

Another challenge is the role of group membership, as individuals who disrespect social rules are often either ignored or ostracized (Leary & Baumeister, 2000). If an individual with schizophrenia cannot control his or her behavior, through no fault of their own (e.g. active hallucinations or paranoid ideation), it is likely that moral transgressions will affect their sense of belonging, as well as threaten inclusivity within the community. The likelihood of social exclusion for those committing social indiscretions is increased, thus creating distance or isolation between society and the transgressor (Rosenblatt et al., 1989).

Many, but not all, individuals with schizophrenia have relatively few social ties (Lipton et al., 1981), leading to the risk of social isolation becoming greater. Living on the perimeter of society could easily contribute to increased feelings of isolation as well as an increased fear of death. Despite the anxiety that is generated from fear of death and death-related issues that occur in both populations (for example, those with schizophrenia as well as in those without), the need to intentionally isolate or be reclusive might override what are considered to be the logical benefits of seeking out protection from others.

Schizophrenia and Cognitive Impairment

The role of cognition is critical in our ability to connect to others, allowing us to think for ourselves, and thus creating a positive image of independence and leadership. Being able to reason, to perceive and to analyse cognitive self-patterns (Amador & Strauss, 1993; Amador et al., 1991) allows others to rely on us. By having an overall positive sense of self, as a function of strong (or at the least average) cognitive abilities, one increases the opportunity for creating social ties and, hopefully, ensuring one's survival. Social consciousness, with respect to being able to decipher relevant cues from both the environment and from others, as well as appropriately responding to social cues, will determine how the individual will best fit in (Markus, 1977).

Severe cognitive dysfunction contributes to poor social integration (Racenstein, 1999; Dickerson et al., 1999; Mueser & Bellack, 1998), as well as to the inability to maintain a conversation, to give appropriate verbal responses, and to maintain eye contact (Mueser & McGurk, 2004; Dickerson et al., 1999; Mueser & Bellack, 1998), making fitting in quite challenging. Because cognitive impairment contributes to poor interpersonal relationships and social interactions (Segrin, 2000), it is common for individuals with severe psychiatric illnesses to withdraw from future interpersonal interactions (Davidson et al., 1998). Lysaker & Davis (2004), Corrigan et al. (1992) and Lida et al. (1992) have suggested that past information assists in creating a self-schema that helps to cognitively formulate patterns of behavior in social situations from which to base future behavior. This implies that an awareness of our social environment is linked to specific cognitive abilities that, in individuals with schizophrenia, are not likely to be highly developed (Corrigan et al., 1992).

Because 'self-schemata are cognitive generalizations about the self, derived from experience, that organize and guide the processing of the self-related information contained in an individual's social experience' (Markus, 1977, p. 63), the 'self' in individuals with severe mental illness, coupled with defective cognitive processes, results in less than satisfactory social experiences. As Lipton et al. (1981) suggest,

> His need to redefine himself and to find acceptance within the community is hampered not only by his impaired social competence, but by the antagonistic attitudes and reactions of those with whom he has lived and associated for many years. (p. 150)

If one is consistently presented with negative social situations across time, it is inevitable that negative social schemata would develop. The difficulties encountered by individuals with severe mental illness to adhere to social standards would impede their motivation to seek out people who would be beneficial in terms of protection from harm. This becomes apparent with respect to the difficulty of meeting social acceptability. The effort that an individual with a severe mental illness would need to exert in order to meet the minimal standards for what society deems as cognitive attractiveness would be exceedingly demanding. The inability to possess a strong cognitive foundation from which to be independent, as well as socially industrious, implies that the individual would be ignored by his peers and shunned from his community. Left without the cognitive resources to meet basic social criteria, the individual must discover other ways to survive and manage the terror experienced not only of being alone, but of dying alone.

Schizophrenia and Social Attraction

Individuals possessing a high level of self-esteem will more likely be perceived as self-sufficient and resourceful; personality traits that are socially attractive for in-group inclusion and/or membership (Leary & Baumeister, 2000). If these traits are successfully intertwined to form a fabric of social independence, one can then infer that low personal maintenance (i.e. someone who does not need constant care and looking after) is a characteristic that is attractive from both an individualistic and a collectivistic perspective. Taking social attraction one step further, Leary and Baumeister (2000, p. 17) have

stated that 'physically appealing people are sought out more and receive more offers of inclusion than unattractive people'. For many individuals, paying attention to our daily physical appearance is routine. We take a shower, we brush our teeth, we comb our hair, choose clothes that are clean and (sometimes) pressed. We understand that outer appearance has some type of an effect on others. We are accepted into our community because we fit the standards that society values. We also have the capacity to alter our behavior to best represent ourselves in any given social situation. For example, we choose clothes that are appropriate for weddings versus funerals, for work versus leisure and so on. For many individuals with schizophrenia, processing how they appear to others does not come easily, and so making themselves appealing to others is a difficult task.

Schizophrenia and Self-Esteem

Pyszczynski et al. (2004) have suggested that in order to avoid death by unnatural causes, social acceptance, as a function of a strong sense of self, becomes beneficial to reducing the fear of dying, because self-esteem acts as a buffer against (death-related) anxiety (Harmon-Jones et al., 1997). Motivation, as applied within the context of TMT, drives us to increase our self-esteem and feelings of self-worth to gain entry within a group (Mruk, 2006), especially as a function of possessing valued social traits. Sullivan (1954) has argued that the self is made up of appraisals that mirror society. If an individual with a chronic mental illness can display desirable traits and characteristics, it is more likely that he or she will receive appraisals that not only match that of the social norm, but allow them to gain approval and acceptance into a group, thus, reducing his/her existential fear of death and death-related issues.

Many individuals with schizophrenia report a sense of 'invisibility' (McReynolds et al., 2002). This might be translated to mean that although the individual is physically present within his community or society, he is ignored or shunned by the very group to which he belongs. The more social rejection an individual encounters, the less physically visible he will be, and the greater becomes his motivation to seek isolation. We can see how 'feeling invisible' can transfer over to one's sense of self, thereby decreasing the individual's self-esteem, especially when individuals with severe psychiatric illnesses are amongst the most socially excluded individuals in society (Sayce & Measey, 1999; Sayce, 2000).

Although the literature does demonstrate that there are small populations of individuals with schizophrenia that gain a strong and positive sense of self-worth from engaging in such activities as religiosity and employment (Frank, 2009), indicating that they are viable members of their community, Sörgaard et al. (2002) found that the most important predictor of increased self-esteem is that of social contact. However, due to the specific nature of schizophrenia, individuals with severe and chronic mental illness find engaging in, and maintaining, social contact challenging.

Discussion

Freud believed that a society that attempts to control man's instincts ultimately results in the inhibition and sublimation of the individual, and so by default inhibits individual expression (Thompson & Mullahy, 1951). If there is a mismatch between self and society, the likelihood of social inclusion diminishes. If individuals with schizophrenia, or any individual with a severe psychiatric condition, cannot connect with others to find the necessary protection that they seek from death-related fears, instinctually natural behavior, with respect to seeking out others, will at some point be overridden by behavior that reflects the individual's own notion of how to best survive.

Harry Stack Sullivan once stated that '…abnormal adjustment has become habituated…' (Greenberg & Mitchell, 1983, p. 83), referring to those individuals whose behavior is considered abnormal within a specific cultural matrix when compared to expected social standards. In other words, when people become habituated to their disorder, they find ways to manage and get around, even if it creates a contradiction between what is universally logical and what the individual

experiences, as his or her unique sense of reality. Motivation pushes one to seek ways in which to survive, but the power of a community over those who are too cognitively and emotionally weakened may be strong enough to override the need to seek out others for help and protection. Social isolation may not be a function of the disorder, as has been previously suggested (see Planansky & Johnston, 1977), in the same way that diminished self-esteem, or lack thereof, was thought to be consistent with having a severe psychiatric illness (Frank & Davidson, 2014).

Although the theoretical underpinning of TMT addresses what action individuals take to prolong their own mortality, regardless of culture, it does so for the population of individuals without severe psychiatric illnesses. It is possible to conceptualize that although TMT should be applicable to all human beings, part of the paradox is that it may not, at least in theory, be completely transferable or applicable to many folks with schizophrenia.

The second component of the paradox is that although the individual may desire to extend her mortality through seeking out protection from death through group inclusion, it is the individual's own social matrix that prevents her from achieving her goal; social isolation may aide in reducing the angst, as perhaps, social isolation plays more of a protective role than we are currently aware of because being alone is better than being in bad company. From this perspective, why would any individual who is faced with such adversity want to be a part of that society? In the case of many individuals who are psychiatrically challenged, possessing attributes that are socially acceptable is difficult. Although TMT suggests that social inclusion increases one's chances of survival, it rests on the assumption that one must possess social attributes that are worth coveting by others. If one is not worthy of social inclusion, then perhaps retreating into one's own personal world – a self-contained, non-judgemental system that provides safety and security on its own – may be, however illogical by 'normal' standards, the securest place to ensure one's mortality. For many who cannot function in the presence of others, perhaps social isolation is where physical and emotional safety can be found, suggesting that social isolation may prove to be a critical component for self-preservation as well as for dealing with death-related fears.

Conclusion

The purpose of this paper is to draw our attention to an issue that, as previously mentioned, seems so logical that we simply take it for granted; the prevailing thought being that those individuals with schizophrenia fear death in the same way as those without the disorder, However, I do not think this is the case; and I go so far as to contend that social isolation represents something far deeper. If I am correct, then this is where, as a mental health community, we fail. We must continue to question the obvious in our attempts at getting closer to the truth. Until then, the mental health community is performing a disservice to a population of individuals who deserve more than what we are presently offering.

Perhaps the paradox of TMT, as applied to this special population, will begin to allow us to review aspects of the self associated with schizophrenia that are currently under-researched, and begin to alert us to some greater issues facing this unique population. As Mavrogiorgou et al. (2020), state, 'it can be concluded that existential aspects such as death and meaningful life should also be considered within the treatment of patients with severe mental disorders'. As such, creating treatments that include addressing mortality salience would be the next step. It may be the case that if these folks were not shunned by society, their ability to deal with death-related anxiety as a function of acceptance and care might assist in quelling their fears, to the point where their fears become as 'normal' as those without this disorder.

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