

Commentary on An "Incurable" Schizophrenic: The Case of Mr. X

**From "Incurable" Schizophrenic to Person in Recovery:
A Not So Uncommon Story**

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ABSTRACT

In this commentary on Bertram Karon's (2008) case study of Mr. X, I present my perspective from today's clinical, empirical, political, and sociological perspectives, 40 years after Karon began seeing Mr. X. Within this context, I agree with Karon that he most likely "saved" Mr. X's life, keeping him from quite probably destructive electro-convulsive treatment (ECT) and possible suicide, and facilitating Mr. X's return to a full and gratifying social and professional life. In my analysis of Karon's case study, I identify those elements in his treatment that, from today's clinical and empirical evidence, seem to have been effective. A number of these can be seen as consistent with today's model of "assertive community treatment" (ACT), including Karon's daily engagement with Mr. X in natural, "in vivo" settings (like a diner and Mr. X's work setting); Karon's attention to Mr. X's basic needs (like food and employment); and Karon's continuing to supportively spend time with Mr. X over quite a while, even when Mr. X did not immediately appear responsive to this. All of these effective ingredients of the treatment do not require psychoanalytic theory for their explanation. Overall, I am led to conclude that Karon's theoretical, psychoanalytic account of the successful treatment of Mr. X goes beyond the available data, at least the data available to the reader. Much of what Karon describes as effective would also be considered helpful by people with psychotic disorders who have neither been offered nor benefited from psychodynamic insights, and can be accounted for by alternative conceptual frameworks which make fewer theoretical assumptions. I end my commentary with a plea for humility in our attempts to understand the daunting challenge of helping a person "create a livable world" in the face of a condition as complex, dynamic, and seemingly mysterious as schizophrenia.

Key words: schizophrenia; assertive community treatment; psychoanalysis; consumer/survivor movement; recovery

Early in my career, I took little solace from a comment my mentor used to make at times when we would come to a pause in our otherwise lively conversations; a pause that indicated that one of us was stuck, not knowing how to return the other's volley in our game of intellectual

tennis. At these awkward but promising moments — promising in that one or both of us was about to learn something — he would often say: “The more I learn about mental illness, the less I think I know.” It is worth noting that he was at the time considered one of the leading researchers in the world investigating schizophrenia, and that he had at that time over 25 years of experience treating and researching the condition. Rapidly approaching my own 25th year of attempting to treat and to study the condition we refer to as psychosis, I have now come to appreciate the wisdom of this stance, as I have come gradually to appreciate many of the other things he taught me as well. All of this is to say that I, too, have been humbled by my experience and try, therefore, to keep an open mind about the nature of serious mental illnesses and their treatment. I, too, feel that the more I have learned about these conditions, the less I actually know about their nature, their etiology, their course, or their cure.

I thus was intrigued by the invitation to read and comment on a case study by Dr. Bertram Karon (2008). Knowing of him by reputation, I was excited to delve into the details of one of his success stories and to learn about his particular approach to the psychoanalytic treatment of schizophrenia. Having been trained clinically by some of his contemporaries, I was familiar with Karon’s theoretical approach, with psychoanalytic claims about etiology, and with the goals of this form of treatment. From my perspective, therefore, the theoretical essay intertwined with the case material was both distracting and disappointing, as it hovered at a level of abstraction that remained disconnected from Mr. X, from the things we learn about him, and from the choice of interventions which are described. I appreciate, however, that readers who are unfamiliar with the psychoanalytic approach to schizophrenia might have needed this theoretical background to make sense of the case.

Having my own suspicions about the pharmaceutical industry, and being unimpressed by the limited efficacy of anti-psychotic medications, I also was unconcerned about Karon’s attitude toward medications and all the more intrigued to see what treatment might look like without this added complication. Finally, fancying myself to be somewhat of an expert in “recovery” (a term I explain below), as well as an academic who has several friends who experienced psychosis and who now are healthy and happy adults, I had no difficulty imagining X’s condition to meet *DSM-IV-TR* (American Psychiatric Association, 2000) criteria for schizophrenia and no difficulty believing that he had recovered. That is, I was never tempted to think that X must really have had bipolar disorder, knowing well that many people with schizophrenia are able to get their lives back, including at least one psychiatrist (Dan Fisher at the National Empowerment Center) and one clinical psychologist (Patricia Deegan, an international leader of the consumer/survivor movement) whom I consider colleagues.

As a result of these considerations, my commentary will not focus on any of the more potentially controversial or provocative elements of Karon’s case study, but on the case itself. In addition, my perspective on the case is not intended to represent what I imagine I might have thought of the case in the 1960’s, when the majority of the work was carried out, but will instead benefit from the hindsight now available to me looking back from 40 years later. For instance, I do not share the pessimistic attitude of Karon’s colleagues from the 1960’s, to whom he credits the title of his case study: an “incurable” schizophrenic. Having learned from over 30 years of longitudinal outcome research conducted since the 1970’s — to which Karon and his peers thus did not have access at the time of this case — I know that schizophrenia manifests a broad

heterogeneity in outcome and that, when followed over time, a majority of people with this condition are seen to improve (e.g., Carpenter & Kirkpatrick, 1988; Ciompi, 1980; Davidson & McGlashan, 1997; Harding, Zubin & Strauss, 1987; Strauss & Carpenter, 1972, 1974, 1977; Strauss, Hafez, Lieberman & Harding, 1985). I also know from this literature that having been married, having an onset of illness at age 31, and having completed doctoral studies, Mr. X would be considered today to have a relatively good prognosis.

By introducing aspects of our knowledge from 2007 into a case study from 1967 I do not mean to imply that Karon did not in fact save X's life, as they both believe. I also fully believe that Karon's treatment of X saved his life; "saved" at least in the sense of allowing him to return to a full and gratifying life in which X was enabled to use and benefit from his own gifts, talents, and abilities. I believe this because otherwise X would likely have undergone electro-shock therapy (ECT) as planned, would likely not have benefited from the typical treatments of the day, and might very well have become another victim of the discrimination, despair, and hopelessness of the day. Karon at least saved X from committing suicide, from spending the rest of his life in a mental institution, and from having his soul — and eventually his body — slowly broken by well-meaning mental health professionals; outcomes we know to have been common among many other people of that era (e.g., Charlie Parker, Antonin Artaud, and approximately 200,000 other people who died in state mental hospitals in 1963 alone). But the fact that X also did not spend the next 20 to 30 years of his life immersed in and disabled by psychosis, like his fellow academic John Nash, suggests that Karon's treatment was indeed successful as well. In other words, I also believe that Karon saved X's life by offering him an effective form of psychotherapy in which he treated X respectfully as an adult and fellow human being, allowing X to remain in charge of his own life, and encouraging him to identify and build on his own strengths — a phenomenon which tragically is just as uncommon today as it was in 1963.

But what, we may still wonder, were the most effective ingredients of this form of psychotherapy? I found it difficult to discern when and the ways in which Karon's theoretical framework was actually used in treating X, as the details of the case which are presented do not immediately seem to reflect this framework. As Karon acknowledges, it is extremely difficult to convey the therapeutic process as it unfolds over time within and across sessions, just as it is difficult to track and describe the person's incremental progress — which may have been due as much to concurrent life events as to the therapy itself. From the outcome literature described above, as well as from my own clinical experience over the previous 20 years, I know that while Karon's form of treatment of X remains uncommon to this day, the phenomenon X himself represents is not nearly as uncommon. Many people recover from psychosis, even from the schizophrenic variety, and many do so without or even despite the treatments offered by formal mental health services. Outcomes in schizophrenia are in fact better in the developing world, where services are less accessible and more scarce, than they are in presumably more "advanced" countries (Davidson & McGlashan, 1997). So we are left wondering which of the many things Karon did could be taken to constitute the essential ingredients of his approach.

To answer this question, we could accept Karon's account on face value and buy into the legitimacy of his psychoanalytic framework lock, stock, and barrel. That, however, would not constitute much of a commentary. I therefore have decided to opt for two other strategies.

A first strategy, which was not available 40 years ago either, is to consult the mental health consumer/survivor literature which has emerged over the last twenty years and to see which aspects of Karon's approach have been endorsed by other people who have recovered, or consider themselves to be "in recovery," from a serious mental illness. After all, the examples of Fisher and Deegan mentioned above are only two of many examples of people who have had a serious mental illness and who have lived not only to tell the tale but to become visible role models and sources of hope and inspiration for others still suffering under the weight of the illness. Through the effective lobbying of the consumer/survivor movement, we now know that even among those people who are not as fortunate as X — who do not recover fully from the illness — a majority can still figure out how to live safe, dignified, and meaningful lives in the face of the illness. This form of recovery, which we have suggested calling recovery "in" mental illness to differentiate it from the more conventional notion of recovery "from" mental illness (Davidson & Roe, 2007), is becoming an increasingly common phenomenon as the consumer/survivor movement, the field of psychiatric rehabilitation, and, most recently, federal (DHHS, 2003) and state (e.g., Davidson, Kirk, Rockholz, Tondora, O'Connell & Evans, 2007) authorities have spread the word that recovery is indeed possible for everyone. And as these people's lives have improved, they have had much to say about what has helped them along the path of recovery. I will return to this strategy below.

A second strategy is to reflect on Karon's case material through the lens of contemporary community-based treatment and to see which of the aspects of his approach are still in practice today, even though the psychoanalytic framework surrounding it has been jettisoned. While it certainly is true that very few people with schizophrenia are afforded intensive psychotherapy today, it also is true that about 20% of people with schizophrenia are fortunate enough to be offered at least one effective treatment (Lehman & Steinwachs, 1998). One such effective treatment is assertive community treatment or ACT. ACT is considered an "evidence-based" treatment as it has over thirty years of empirical support documenting its effectiveness through numerous clinical trials (Lehman & Steinwachs, 1998). As it is considered an expensive treatment, ACT is most often reserved for those people who are the most disabled and/or are the most difficult to engage in conventional services (e.g., case management), so it is not at all clear that X would have been offered ACT were he to become ill today (as is the case for most people with schizophrenia today who cannot access ACT services). But it does seem to me a fair comparison, nonetheless, to consider which of the components of Karon's approach would be offered to X were he to be one of the fortunate ones. These two strategies are intertwined below.

Let us begin, then, with the engagement process early in the course of the treatment. Karon describes meeting X every day for the first seven days and then decreasing the frequency of contacts to three times per week, and eventually once per week, as X's condition improved. During those initial meetings, Karon described the therapist as being "willing and able to deal with anything and go anywhere the patient needs to go, no matter how scary." He continues: "If you know things that will help the patient with the patient's current concerns (not yours), you let them know." Karon describes how patients typically respond to this approach as follows: "The patient is often surprised that you have anything to offer that actually helps, that you care about what they are afraid of, and that you listen carefully and take seriously what they say" (p. 5).

To this point in the story, the overlap between Karon's perspective and both ACT and the consumer/survivor literature is striking. ACT Teams are available to their clients 24 hours a day, seven days a week, and vary the number of contacts staff have with a given person based on what the person needs at the time. It is not at all unusual for ACT Teams to visit new clients several days per week, perhaps even several times within a day, to start, especially if the person is having a very difficult time. As the person gets to know the staff, becomes acculturated to the team, and begins having fewer crises, staff typically decrease the frequency of their contacts to a few times per week and eventually to weekly visits until the person "graduates" from the team. ACT staff usually do not have private offices, and the term visit—rather than session—is used because ACT staff typically see their clients *in vivo*, that is in the natural community settings where they live, work, play, and have difficulties. What staff are expected to focus on early in the course of the relationship with a new client is assessing the person's basic needs, goals, and priorities based on what the person has to say as opposed to what the staff thinks should be important. Often, especially when outreaching to individuals who are homeless or who refuse treatment, this takes the form of addressing basic needs for food, shelter, income, employment, and companionship. People who have received ACT services after refusing office-based care have reported that it was helpful to be able to develop trust in the staff gradually over time, as the staff continued to visit them consistently regardless of what they said or did, and that they eventually did welcome, with some degree of surprise, the recognition that the staff actually did have things to offer that could, and did, benefit them (Chinman, Allende, Bailey, Maust & Davidson, 1999). And all of this takes place before any traditional sense of "treatment" occurs.

Considered a breach of neutrality by most other forms of psychodynamic therapy, Karon reports his first conversation with X taking place in a white-tiled diner. His rationale for this was that X had been refusing to eat, and that therapy deals with the "obvious problems" first (p. 14). In order to convince X to enter the diner to begin with, Karon had to assure him that people would be more likely to think he was drunk than "crazy," and that, if he did indeed vomit, he would not be "the first drunk who threw up in here tonight" (p. 14). Although X does not eat the first time, by the third time they frequent the diner Karon reports X having a meal after complaining that all he was doing during his sessions was watch his therapist eat. The only other information we are given about these interactions is that during the first exchange Karon talked to X about "food, the fear of poisoning, and its possible origins" while he ate, reassuring X indirectly that the food was not poisoned (p. 15). Karon also reports that sometime during this first conversation he assured X that he would not kill him and that he would not let anyone else kill him either (p. 7). How are we to understand these interchanges?

According to Karon's theory, schizophrenia is a "chronic terror syndrome" in which the person is convinced that he or she is about to be annihilated, although the exact mechanism of annihilation is not always specified (pp. 3, 7). It is based on this premise, and on Karon's view that X's relationship with his mother was one through which he was emotionally poisoned, that he offers X assurances that he will not kill him or allow him to be killed, and that the food they are eating, or could eat, was not poisoned. In most cases, these type of interventions would not be offered by ACT staff, and thereby represent a difference in approach. But is there evidence in the case history that these particular interventions helped to put X at ease, or that they were effective in enabling the treatment to progress? Karon's description of X's response was to say in

relation to his comments about being killed that: "This patient neither acted as if that were very helpful nor as if it were strange. Probably he did not believe me, but he did not say so" (p. 7).

It certainly is possible that Karon's interpretations were based on accurate insights into X's unconscious processes, and possible as well that additional case material with which we were not provided would attest to this accuracy. In the absence of such data, however, we are left wondering as to whether this is the only possible explanation for X's behavior or the most reasonable account of why Karon's other interventions seemed effective in engaging X into a therapeutic relationship. Consider, for example, the following vignette described by a woman in one of our earlier studies who was offered the opportunity to befriend, and be befriended by, a volunteer from her community who took an interest in accompanying her on social and recreational outings. In the following passage, she describes what eating was like when she was alone and what it has become like since she has made a new friend. She says:

I would open a can and eat right out of the can, because I knew I had to put some food in me, but I had no enthusiasm of wanting to make it because I was going to eat it by myself. The only person I had to talk to was the television. So I would open a can of beans, wouldn't even heat it, because I just knew that I had to put food in me... I [wouldn't] go out to a restaurant because I don't like the emptiness. I mean you just sit there and you buy your meal. It doesn't taste the same as when you're eating it with somebody ... like when you go to Burger King, like on the first [of the month] I can go to Burger King [because] I've got money. I've got a reason to go in there because I've got money, but I'm alone. I sit down at the table. I eat a hamburger. I'm just eating a hamburger. But when I go in with somebody else, and I'm sitting there at the table and eating it, she'll say 'Oh, is your hamburger good?' Then the hamburger becomes noticeable, and then your mind starts to think about the taste. But when you're sitting there by yourself, you're just eating it and then you go out the door. I don't want to eat really, because it doesn't taste good when I'm alone. [But] when you go out [and] you're not alone, you're able to eat talking to somebody, that can of beans could have been in a gold bowl instead of just a plain, cold tin can (quoted in Davidson, Stayner, Nickou, Styron, Rowe & Chinman, 2001, p. 380-1).

This woman, who also suffered from schizophrenia, describes not wanting to eat because her food would have no taste when she was alone, with only the television for company. She also describes the difference not having to eat alone can make for someone in her condition. Although X was married and therefore not alone, it is still possible to imagine that he might have had reasons for not eating other than having fantasies of being poisoned, and that he gradually came to eat in Karon's company for reasons other than because he was reassured that he would not be murdered. As it stands, I have difficulty accepting these theoretical interpretations in the absence of additional data. While it is quite possible that X was experiencing terror, it is equally possible that this was a sense of terror in the face of the early manifestations of psychosis (e.g., anomalous experiences of hearing voices, feeling that others could read his thoughts, etc.) rather than the cause of the psychosis itself. In the vignette above, I doubt that this woman's friend assured her either that the food was not poisoned or that she would not kill her or allow her to be killed by anyone else. The experiences nonetheless seemed to be helpful to her.

As a final consideration of this aspect of the case, I do not know how Karon could make such an assurance in good faith, as it would not be possible for him to protect X from any and all

possible accidents or assaults. How, for example, could he prevent X from being killed in an automobile accident in between sessions? Were I in X's shoes, such a promise would raise concerns for me about the therapist's credibility. In a similar incident, Karon assures X one year into the treatment that "under the stresses of ordinary life" he "will never be psychotic again" (p. 19). This conclusion is once again based on Karon's theoretical formulation and his belief that he has helped to address the fundamental threats which led X to become psychotic in the first place. As much as I, too, would like to offer clients such assurances, I do not believe that it is within my power to issue them guarantees. I worry that it was not within Karon's either, regardless of his own degree of confidence. I will return to this concern below.

Before closing, I would like to consider a few more examples of interventions described by Karon which might be used today, and which have been endorsed by people in recovery as being helpful. Karon describes one of the goals of treatment as the therapist helping "the patient create a livable world" (p. 9). One example of his doing so with X — and again in a way which I imagine would have violated the therapeutic boundaries of other psychoanalytic approaches — was to accompany X to his first class when he returned to teaching and to wait outside of the classroom until the class was over. He did this, he reports, because he knew X was "scared" of returning to work (p. 18). Karon's accompaniment of X to the classroom and his standing by outside of the room for the duration of the class was intended to help X tolerate and manage this anxiety. This, too, was successful.

In the forty years since, such interventions have, in fact, been found to be very helpful for people with psychosis who are attempting to return to school or work. Such interventions form the interpersonal core of the established approaches of "supported education" and "supported employment"; two more of the so-called "evidence-based practices" for schizophrenia which have been shown to improve educational and vocational outcomes (e.g., Becker & Drake, 1994; Unger, 1998; Wehman, 1986). These interventions can be provided by ACT staff, but also can be provided by vocational rehabilitation practitioners outside of the framework of ACT. Either way, staff accompany people to the classroom or the job site for an indefinite period of time until the person feels comfortable and confident enough to go by him or herself. In the case of supported employment, however, the staff may take the additional step of actually going into the room with the person and working alongside of him or her to help the person learn the job. In these cases, too, it is understood that the person is scared to return to school or to work, but this fear is understood to be due primarily to the situation rather than to the illness. In other words, X might have been scared to return to work not because of the lingering sense of terror which Karon viewed as part of his illness, but rather because he had not worked in six months and was not yet sure he was well enough to do so. Unfortunately for him, as for everyone else, the only way to find out if he was well enough was to try, and having his therapist accompany him and wait outside the door was comforting and enabled him to overcome his fears. Such interventions continue to be a good idea and have been endorsed by people in recovery as extremely helpful. Although again I question Karon's psychoanalytic account for why he did this, I admire his foresight in sensing that this was a needed and useful support for the person, and his courage in doing so despite the fact that it violated conventional psychoanalytic boundaries.

There are two final examples worth mentioning, which are the only examples Karon provides of his responses to X's concerns about his parents. In the first case, he describes how

X's parents criticized and demeaned both X and his brother, who had become a successful businessman. When talking to X, they were reported only to talk "about how much money his brother made and how little he did," while when talking with X's brother they were reported to talk only about how brilliant X was, with the obvious implication being that the brother was not (pp. 16). After commenting with good humor that X's parents were neither brilliant nor rich, Karon describes explaining to X how one person cannot do everything in life, such that if you decide to pursue academics you most likely will not make much money, and if you decide to pursue business you most likely will not earn a Ph.D. As he concludes: "There just isn't time to do everything, but to do either one is an achievement" (p. 17). In the other instance, X reports with "great shame" to Karon that he paid a \$40 veterinary fee to have his cat's broken leg attended to when he fell from a tree. His sense of shame came from his expectation that his parents would have disapproved of such a frivolous waste of money on an animal, as they had not approved of pets and only considered animals to be "dirty" (p. 19). To this disclosure, Karon replied that "of course" X paid the fee to tend his cat because "he is your friend" (p. 19).

These are two lovely accounts of poignant moments in psychotherapy. In both cases, the therapist is challenging the behavior of the clients' parents and offering an alternative scenario, painting an alternative world, for the client to consider. Not all parents detest animals, and most parents would be proud of children who became either successful business people or academics. It is useful for X to be provided with this information, and for him to be guided in the process of rewriting his history and creating a new and different, more livable, future. It is not clear, however, what any of this has to do with schizophrenia. Writing as a person whose parents coincidentally also detested "dirty" animals (but who now has two terrific, and clean, dogs whose veterinary bills have far exceeded \$40, even in 1960's terms), and as an academic whose parents also only seem to care about how much money he makes (or, more to the point, doesn't make), I can readily empathize with X's concerns and appreciate Karon's sensitive and helpful responses. But I do not have, nor have I had, schizophrenia. And it is not at all clear from Karon's description what these two dynamics had to do with X's particular case of schizophrenia either.

In closing, I am led to conclude that Karon's theoretical account of the successful treatment of Mr. X goes beyond the available data, at least the data available to the reader. Much of what Karon describes as effective would also be considered helpful by people with psychotic disorders who have neither been offered nor benefited from psychodynamic insights, and can be accounted for by alternative conceptual frameworks which make fewer theoretical assumptions. Finally, there is an unsettling aspect to Karon's description which appears to be attributable to his investment in a psychoanalytic perspective. The two examples provided above were of his assuring the patient that he would not let him be killed and that with only the stresses of "ordinary life" the patient would never again become psychotic. Even if these interventions were based on sound psychoanalytic principles, they reflect a degree of certainty for which I cannot imagine there being a credible theoretical explanation. Gardner's (1971) volume which contains both Freud's account of his treatment of the Wolf-Man and the Wolf-Man's own retrospective account of his relationship with Freud is remarkable in the extent to which their respective accounts of what was helpful differ. Even without the advantage of hearing from Mr. X what he found helpful about Karon's treatment, other first-person accounts of people in recovery suggest that the degree of confidence Karon appears to have in his own account may be misplaced. This

confidence is reflected, among other places, in the fact that he uses the phrase "of course" no fewer than 20 times throughout the case summary.

Given my own intellectual lineage (which I described above), along with my own years of experience working with people with psychosis, I am much more comfortable with much less certainty. Given his many more years of clinical experience, I would hope that Karon, too, would agree that perhaps a bit more humility is warranted by the daunting challenge of helping a person "create a livable world" in the face of a condition as complex, dynamic, and seemingly mysterious as schizophrenia.

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