

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

Psychotherapy Can Be Helpful for Schizophrenics

GARY R. VANDENBOS^{a,b}

^a Publisher for the American Psychological Association, Washington, DC

^b Correspondence concerning this article should be addressed to Gary R. VandenBos, American Psychological Association, 750 First St NE, Washington, DC 20002-4242.

Email: gary@apa.org

ABSTRACT

Karon's work with Mr. X reflects the model that he and I use generally in doing psychoanalytic psychotherapy with schizophrenic patients. In my experience, this work is frequently met with considerable skepticism and at times outright antagonism from the professional mental health community. In this commentary I explore 10 possible reasons for these negative reactions and why I believe the reactions are off target from the central clinical fact that Karon's model has a track record of success. These reasons include such areas as the roles of diagnosis, medication, a detailed developmental history, the therapist's distinctive personality and style, and the therapist's level of activity in treating patients diagnosed as schizophrenic.

key words: schizophrenia; psychoanalytic treatment

It was enjoyable and informative to read the clinical case study of Mr. X by Bertram Karon (2008). I have known Dr. Karon since 1967, and I have heard him present in lectures, seminars, and at conferences many times. As I read his words, I can "hear" him saying them. As always, I hear his depth of understanding and appreciation of the experiential world in which an individual with schizophrenia lives, and I hear his intense efforts to help build a "safe world" in which the patient with schizophrenia can feel less threatened and start tentatively and inconsistently to relate and communicate with the therapist, initially in a vague, complex, and difficult to understand manner. I have found his style, technique, and his actual words in such therapy to be very helpful to the typically terrified individuals with schizophrenia. Dr. Karon influenced me early in my training in conjunction with my role as the Senior Research Coordinator on the program he directed, the below-described "Michigan State Psychotherapy with Schizophrenics Project." Much of my clinical style with severely disturbed patients is modeled after him. My own clinical success with schizophrenic patients is likewise similar to his, and I have lectured broadly on the psychotherapeutic process of treating individuals with

schizophrenia.¹

It is my experience that many mental health professionals seemingly do not want to hear that schizophrenic patients can be greatly helped, perhaps “cured,” through psychotherapy. The reactions to presentations suggesting that schizophrenics are treatable with psychotherapy are often intense. I would like to focus my commentary on Karon’s case study by mentioning and discussing the ten most common reactions that I have received from professional audiences when I present on doing psychotherapy with schizophrenics.

TEN COMMON RESPONSES (OR OBJECTIONS)

1. The Patient Must Have Been Misdiagnosed

The first and most frequent response, during the discussion period after a presentation reporting on the successful treatment of schizophrenic patient with psychotherapy, is that the patient or patients must have been misdiagnosed. To this possible objection, I can only observe that it appears most mental health professionals seem to have little confidence in the diagnostic abilities of their colleagues. In Karon’s present case, the patient had been diagnosed by five to six psychiatrists or psychologists as “schizophrenic,” before Karon ever met the patient. Is it credible

¹ In my role as the Senior Research Coordinator of the Michigan State Psychotherapy Project with Schizophrenics, I had access to Karon twice a day for 90-minutes during the trips to and from Detroit at a rate of about 180-200 days per year for two years. I asked a lot of questions about symptoms and techniques and interventions. I listened and reflected and more actively questioned, as I was a graduate student. I also tried out what Karon advocated with patients in several clinical settings, and I reflected on those personal clinical “experiments.”

The actual research project was done by 1970, and the major data analyses were done by 1971-1972. Karon and I proceeded to write and publish on the research findings for the next 4-5 years. Well before the final writing of the research findings of the project was over, I was on the staff of a community mental health center (where I later became the Director), and I continued to personally and clinically “experiment” with Bert’s techniques (and train and supervise others in doing so), which was why I felt comfortable, in 1977, to join with him in writing a book on “his approach” to doing psychotherapy with seriously disturbed patients, as I understood it.

I was in graduate school from 1966 though 1973. By the time I graduated, my relationship with Bert had become as “colleagues,” albeit, senior colleague to junior colleague. We worked together weekly on Fridays at Michigan State, from 1971 through October, 1977, on various draft journal manuscripts as well as our book, *Psychotherapy of Schizophrenia: The Treatment of Choice* (Karon & VandenBos, 1981). The last 3-4 months of that time, in 1977, we were writing 40-hours per week to create the first, 900-page draft of our eventual 1981 book. We then continued to re-work that book material for 2-3 years, before we were satisfied that it was clear and direct and properly detailed. for formal publication.

Since publishing the book, Karon and I have continued our professional collaboration. During the 1982-1984 period, when I was in Norway, we organized a joint lecture series across 3-4 countries. We have continued to provide each other editorial feedback on what we write, and we have continued to write a few things together (but a bit less than I would have preferred). And, when I have a new and particularly challenging clinical case, I talk with Bert about my clinical understanding of the case and how I should best approach it. And, as he taught me, I listen, I experiment, and I determine what might be the best approach for me to use and for the client to experience in order to help the patient in their personal change process (and I listen and utilize the feedback I get from the patient in this process).

that that many diagnosing professionals were so consistently and absolutely wrong? I think not. Karon accepted the diagnosis that others put on the patient, and Karon concluded that the diagnosis was correct based on the patient's symptoms, life experiences, coping style, and material that continued to emerge as the therapy progressed. But, because the patient improved, there is an immediate response by some that the improvement is obviously evidence that the diagnosis was wrong. Is there a little circular reason to this response? I think so. This response is ever made about the research findings from the Michigan State Psychotherapy with Schizophrenics Project (Karon & VandenBos, 1970, 1972, 1976, 1978, 1981). In this research project, an independent clinical assessment team conducted clinical interviews and psychological testing of potential patients for the research project. They started with a pool of 20-25 new admissions each week, but could quickly eliminate a number of patients as non-schizophrenic or having some other clinical feature which made a clear diagnosis of schizophrenia questionable. A smaller subset of 4-7 individuals were assessed more closely, before the clinical team presented for random assignment to treatment groups three individuals about whom there was a consensus that they were "clearly schizophrenic" with similar degrees of severity of symptoms. Nonetheless, the most frequent response to hearing the findings of this treatment research project is to raise the issue of misdiagnoses. I can find no credibility to the claim of "must be misdiagnosed," rather I believe it is an emotion-based defense against even considering that schizophrenics can be treated in psychotherapy.

2. Schizophrenics Can Only Be Treated with Medication

The second most common response is to say "everyone knows that schizophrenics cannot be treated with psychotherapy, and the only effective treatment of schizophrenia is medication." I often find this remark puzzling, particularly when it is made immediately after hearing a detailed presentation of a research project suggesting the opposite or hearing a detailed clinical case study of treatment success using psychotherapy with an individual with schizophrenia. This response almost sounds like primitive denial. The cognitive mind-set and professional training in psychology and psychiatry seems to have been so dominated by the influences of pharmacological firms that it is almost impossible for many mental health professionals to even consider an alternative idea. When I see this level of denial, I have to wonder, as a clinician, if there is not an intense psychological reaction behind it. I think there is. The type of strange, confusing, bizarre, and scary material that comes up in such in-depth, experiential involvement with such patients is intensely frightening. One has to consider the possibility of an internal, perhaps unconscious, reaction of "if he can do that, I should be able to do that" (and "either I cannot do it, or I am too afraid to do it — and I do not want to admit that to myself"). Actually, not all psychotherapists can successfully treat schizophrenics. My experience, across several treatment settings, is that only about half of all psychotherapists can comfortably and successfully treat schizophrenics, for a variety of reasons. That does not mean that they are not good therapists; it just means that they are good therapists with other types of patients. There are some types of patients that I have learned from experience that I am not particularly effective with, and I no longer attempt to treat such patients because I reflect on and learn from my clinical experience.

3. The Therapist Is Unique

The third response is a reluctant acknowledgement that this therapist appears to have successfully treated this individual with schizophrenia in psychotherapy, but the only reason for the clinical success is that the therapist is a rare and gifted “master clinician”. The speaker, however, usually goes on to say that the approach and specific techniques probably cannot be taught, because they are so integrated with the personality of the therapist and his intuitive style and keen perceivable abilities. That is simply not my experience. I watched Karon for over 10 years train young psychologists to do such clinical work, and I know that many of them continue to do effective therapy with individuals with schizophrenia long after their initial training with Karon. I, too, have taught others how to do psychotherapy with schizophrenic patients, most particularly in my 25-year association with the University of Bergen and the University Hospital at Sandviken in Norway. I personally know some 20 psychologists and psychiatrists in Norway who are regularly and successfully treating schizophrenics with psychotherapy, and there is a still larger group of therapists in Norway whom I know about but have not personally met. The way to conceptualize schizophrenic patients, their probable earlier life experiences, their cognitive distortions of those experiences, the methods of initially approaching and treating the patient, and so forth are all teachable and learnable – and it also must be acknowledged that doing psychotherapy with individuals with schizophrenia is a mentally and emotionally challenging (and frightening) process.

4. The Therapist is Too Intrusive

The fourth most frequent response, particularly after seeing either a live or a videotaped demonstration of psychotherapy with a patient with schizophrenia, is to say something like “that is too intrusive for me, he talked too much, he never gave the patient a chance to talk, and he was far too certain about what he said” (and, often unsaid but clearly implied, “and, that approach would not be helpful to me”). But, the mental health professional making these comments is not schizophrenic, and, hence, if the individual was in psychotherapy with Karon, Karon would not respond or talk in such a manner. Viewing a live demonstration by Karon or me of psychotherapy with a schizophrenic individual is usually an intense experience, with dramatic events and strong language. The patient has reactions to the session (and mostly positive ones); observers also have reactions (and more often negative ones). I think the reactions of the observers are often more intense than they expected or than they generally experience in their own life – and this intensity seems to push them into a more personalized reflection on how they would react to the intervention and whether or not it would be helpful to them. But, they are making that assessment at that moment from their non-schizophrenic experience of the world – and not from the experiential and cognitive belief system of the schizophrenic individual.

5. It's Not “Psychoanalysis”

After the four typical responses described above, the reactions start to become less based on emotional reactions and tend to be more cognitive and conceptual – relating to technique, use of medication, the complexity of the clinical material presented by individuals with schizophrenia,

and the possibilities of alternative treatment approaches with schizophrenics. I will continue using the phrase “next most frequent”, but, in reality the balance of the responses that I will describe could come in any order. I will now also start to introduce reasons for doing specific things in therapy with schizophrenics, describe clinical techniques, and introduce actual examples of talking with patients in this commentary on Karon’s case study.

The fifth most frequent response is often about whether or not this is psychoanalysis (or even psychoanalytic therapy). I do not believe one can technically call the form of psychotherapy that Karon does “psychoanalysis.” It makes too many exceptions of typically expected technique for the use of that “name.” However, at the very least it is a form of psychoanalytically-informed psychotherapy. Much of the theory behind it is psychoanalytic in nature, and a number of the specific interventions can be clearly seen as psychoanalytic. However, as I believe Karon and I wrote in our 1981 book, *Psychotherapy with Schizophrenia: The Treatment of Choice*, theory belongs in the head of the therapist doing psychotherapy with schizophrenics, not in his or her mouth. “Words” are very powerful, both in terms of causing schizophrenia and in curing it. The successful therapist for individuals with schizophrenia must use “words” to create a healthier world – a world in which the patient can live without an ever-present sense of fear; a world in which it is safe to talk about and explore the worst possibilities about behaviors between individuals; and a world in which intense and frightening images, extreme emotions, and memories are discussed and explored, and new (and safer) models of the world, people, interpersonal relations, the past, and the future can be presented, explored, and tried out. What it takes to do this may or may not look like what a third-party observer might expect to see of a therapist doing psychoanalytic therapy, but, remember, in these cases the patient is a schizophrenic.

6. Shouldn’t Medication Be Used with Schizophrenics?

The sixth most frequent response is about whether or not medication should be used in treating schizophrenics. In many ways, I now believe that this is a non-issue. Medication is helpful for some patients, probably 35%. It is also not helpful, and perhaps harmful, for some patients, probably 25%. For the remaining patients, it seems not to matter too much one way or the other. What is critical is that the patient not be on too high a dosage such that they do not have access to their full range of emotional reactions and that they do not have access to all of their mental capacities – as these are critical to doing successful psychotherapy. If the patient comes to therapy on medication, neither Karon nor I force them to stop their medication. That would be a violation of our beliefs about what the therapist must do to create a “safe world” for the patient, as well as being seen by the patient as “a giver, not a taker”. If the patient believes that medication is critical to their survival, let the patient take the medication, because, as the psychotherapy continues and the patient improves, the patient eventually will re-assess the role of the medication in their life (and they will probably stop taking them, as they benefit more and more from “words”).

However, I would also add that I do ask therapists who come to me for supervision of psychotherapy with schizophrenics to do everything in their power to get the patient off

medications or at an extremely low dosage for that particular case that I will be supervising them on. I do this because I have found that those who are trained to do psychotherapy with patients not on medication will learn the “power of words” in the treatment of schizophrenia – and will truly know that they were the active ingredients that caused the change in the patient. I have observed that most therapists who try to learn how to do psychotherapy with schizophrenic patients who are simultaneously on standard dosages of medication rarely know whether or not it was them or the drugs which helped the patient, and they, thus, have little or no confidence in their clinical abilities in doing psychotherapy with schizophrenics.

7. Therapy Is Impossible Without a Detailed History

The seventh most frequent response is that it is impossible to do psychotherapy with an individual with schizophrenia without doing a long and detailed history with the patient. It is true that both Karon and I recommend that the therapist approaching a new schizophrenic patient for the first time use that first meeting to actually “do” psychotherapy with the patient – and not waste the patient’s time doing yet another social and medical history. It is not that we believe that such information is totally unnecessary, but, rather, in most cases, the information typically gathered in such an intake session is already available or easily available to therapists, if they look in the patient’s clinical file. We always recommend reviewing whatever information is available on the patient before seeing the patient, if possible. But, we also strongly believe that you only have one opportunity to start a therapeutic relationship with a schizophrenic patient – and it is the first time you meet the patient, so we recommend not wasting it.

Our goal is to “do something helpful” for the patient in the very first meeting with the patient. This might be something small, such as helping a confusing and disoriented patient understand how they ended up in the hospital or figuring out the psychological core of a dramatic symptom that the patient is manifesting. If the therapist focuses on the therapist’s own need to get oriented in terms of the patient and their patient’s behavior and symptoms, then the patient will experience the therapist as taking care of the therapist’s needs and not attending to the patient’s needs (or, in short, therapist will be experienced as “a taker, and NOT a giver”). Why start your contacts with a new schizophrenic patient by reinforcing the patient’s already held belief that mental health professionals do not have much help to give them?

8. It Sounds Too Easy

The eighth most frequent response is that we make it sound so easy to do successful psychotherapy with schizophrenics. This is wrong. It is very hard clinical work. This response, at least in part, I do not understand, because I experience myself as verbally describing so much about the vague, confusing, inconsistent, difficult-to-understand material that the schizophrenic presents in therapy – as well as the intense emotional reactions of both the therapist and the patient to the material presented. But, it may be that we need to describe how, particularly in concrete examples.

Psychotherapy with schizophrenics is hard, emotionally draining, and intellectually challenging clinical work. If you are not confident that your clinical efforts will be helpful, it is hard to either press on doing the work or to tolerate the awful feelings that can be generated in the therapist. I sometimes worry that I will bore an audience if I describe the 10-12 ideas that I generated about the possible meaning of the patient's symptoms and the 5-6 ones that I explored before the patient (or the patient's behaviors and symptoms) provided me with clues that I was finally on the "right track" in understanding and exploring and describing earlier events in their life and the concept about the world that they formed in response to those events. Thus, in part, I believe that this response from listeners is artificial in as much that it is a reaction to the effectiveness of the overall communication process between professionals, rather than the therapy itself or the details of the patient. Maybe Karon and I need to describe a few more of our own "false leads" with the patient, before presenting our final understanding of the events, the patient's experience of the events, and how the patient incorporate those two sets of data in their perceptual framework and world view.

9. The Therapist Comes on Too Strong

The ninth most frequent response is to claim that the therapist is too strong, too certain, and too directive. This, I believe, is the result of not appreciating the experiential world of the schizophrenic patient. They are overwhelmed. They feel beaten down. They feel weak and ineffective. And, they feel terrified. They need a therapist who is strong, and they need a therapist who they can trust to protect them and help them. Being strong and certain about the "right things" (e.g., things that matter to a given patient at a specific moment) when the patient feels weak and uncertain is part of how the therapist uses "words" to help to create a "safe place" in which the patient can live, function, and explore their own life and experiences, even if initially it is only for 20-30 minutes at a time.

A strong and confident therapist is most critically needed by the therapist early in psychotherapy with an individual with schizophrenia. Consider how we might talk to a patient:

That shouldn't have happened to you, it shouldn't have happened to anyone, but something awful did happen to you, and it hurt you, and anyone who experienced what you experienced would have symptoms just like you are having now, but you don't need to stay this way, it can be changed, and by talking and exploring your life and your experiences, you and I can change it, you will be able to better understanding what did and did not happen to you, and you can think afresh about the nature of interpersonal relationships, so you can experience new events, such as our work together, with a fresh, new view of events.

I hope the reader can "hear" the empathic understanding in the above statement, the normalizing of the patient's coping with awful events, and the statement of the certainty of the possibility of change and improvement. With his "words," the therapist is symbolically starting to build an alternative world in which the patient can eventually be moved. This is a world that is a safer and kinder one than the the patient is currently living in. This is a world the patient builds based on actual events in their life and their (correct or incorrect) understanding of the meaning of those events.

10. The Therapist Seems Arbitrarily Assertive

The tenth most frequent response is closely related to the ninth one but just slightly different. This response is that the therapist is arbitrarily assertive, often about issues that the third party believes is marginally relevant or even totally unimportant. But, this, too, is directly related to an assumption about how best to work clinically with schizophrenics. We truly believe in starting each session “where the patient is at,” addressing whatever is on the patient’s mind, and having them start talking about it. It is part of paying attention to the patient’s needs as the patient articulates them. If the patient starts by talking about how awful it is to be living in a hospital and having nurses and cleaning staff moving their personal items, the therapist should start with that content as well, except in the rare cases of when suicidal or homicidal impulses are obviously present and are demanding immediate attention. But, even in the case of the exceptions, it is usually possible to start by commenting on the material presented by the patient and moving the therapist’s comment around to the suicidal or homicidal topic.

For example, assuming there is pressing suicidal matters to discuss, one could say:

Yes, a hospital is an awful place to live, but, at the moment, you need the protection the hospital provides, even though being in here creates some other problems you would not experience if you were elsewhere. I will tell the staff to stop moving your personal things in your room without your permission, and I am sure they will do it less, but probably not stop completely.

But, you know, I imagine that having people invade your space and move your things makes you angry. It sure would make me angry. Anger is one of the most difficult human emotions, and most human beings have great difficulty handling intense anger, just as I am sure you do. And, it is difficult to know what to do with such anger, particularly when you are in a confined space like this hospital.

You probably noticed that some of the patients sort of act out their angry feelings by hitting someone. Others direct their justifiable anger towards others against themselves in one way or another. I have been told by several staff members that you have been threatening to harm yourself, break a window and cut your arms with the pieces of glass. Is that true? Is there something about people invading your personal space that makes you angry that the only way you can think of discharging it is by threatening to harm yourself or actually harming yourself in order to prove to the staff how unhelpful they are?

That’s just my roaming thoughts. Can you tell me more about your thoughts and feelings about others invading your space, moving your personal items? Do you think it is related to your threats to harm yourself?

CONCLUSIONS

Of the ten common responses described above, the first eight are largely distractions. They do not focus on the actual material being presented and described. They do not consider the strengths and weaknesses of the overall ways of understanding the individual with schizophrenia,

the model of schizophrenic functioning, the methods for understanding and exploring the clinical material as it emerges in the therapy session, the conceptualization of the purposes of the various clinical interventions, and the actual words used in making such interventions. The ninth and tenth responses described above, however, do start to touch on matters of what is actually done, and how it is done, in therapy (and why). But, in professional meetings, the last two responses are generally presented as if they represent clinical “errors,” rather than being clinical approaches or techniques to be considered for their potential value as well as their potential risks.

I am looking forward to reading the other commentaries on the Karon case study and learning about the views of the others providing comments on the case, and what it illustrates about the nature of schizophrenia, and the comparative value/risk of the techniques described by Karon. One observation about the organization of the Karon case study might be noted. Relatively little of the first half of the study is actual case material. It is as if Karon is trying to anticipate some of the “usual” comments and criticisms of his clinical and research presentations and to defuse them, in the apparent hope of helping to get those providing comments on his approach to do so, and then to focus on specific interventions with schizophrenics. I’m concerned that putting them “up front” might actually result in encouraging those providing comments to focus on the “distractions” rather than the actual clinical material and actual clinical interventions.

In sum, Karon’s work and the model he and I use in doing psychoanalytic therapy with schizophrenic patients has provoked a good deal of skepticism and at times outright antagonism from the professional mental health community. In this commentary I have focused on exploring some of the possible reasons for these negative reactions and why I believe the reactions are off target from what should be the central question for our professional: Does Karon’s model, as illustrated by the case of Mr. X, lead to the rehabilitation of schizophrenic patients? My clinical experience and research over many years leads me to answer this question “definitely yes!”

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