

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

Karon's Case of "Mr. X" and the "International Society for the Psychological Treatments of Schizophrenia and Other Psychoses" (ISPS)

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ABSTRACT

This Commentary on the case study of Mr. X places Bertram Karon's (2008) work in the contexts of (a) the current treatment of people suffering from psychotic disorders; (b) Karon's historical connections with the ideas of such pioneering, humanistically oriented, psychodynamic psychiatrists as Frieda Fromm-Reichmann and Sándor Ferenczi; (c) the mission and work of the International Society for the Psychological Treatments of Schizophrenia and Other Psychoses (ISPS) and its U.S. chapter (ISPS-US); and (d) the ongoing struggle in psychiatry over the evidential legitimacy of the psychodynamic treatment of psychosis and schizophrenia. I conclude by pointing out that empirical details about process and outcome in the psychodynamic treatment of schizophrenia as documented in cases like Karon's help to provide one source of such evidential legitimacy.

Key words: psychodynamic psychotherapy; psychosis; schizophrenia; ISPS; ISPS-US

CONTEXT

My Commentary on Bertram Karon's (2008) case study of Mr. X takes place in the context of our collaborative work over many years in the International Society for the Psychological Treatments of Schizophrenia and Other Psychoses (ISPS ¹), particularly in the U.S. chapter (ISPS-US) of that organization. (I have been President of ISPS-US since 1998 and Treasurer since 2006 and Executive Board Member of ISPS since 2000).

First some background on ISPS. ISPS is a nonprofit organization that was initiated in 1956 by Doctors Gaetano Benedetti and Christian Müller "to go beyond a biological-

¹ formerly known as the "International Symposium for the Psychotherapy of Schizophrenia"

reductionistic orientation and to gain a psychoanalytic understanding of the complex illness of schizophrenia, . . . [and to] promote the humane, comprehensive, and in-depth treatment of psychotic disorders" (ISPS-US, 2007). Today it has a total of over 1000 members in 15 national chapters in a variety of worldwide locations, including the United States, the United Kingdom, New Zealand, Australia, Norway, Sweden, Denmark, the Netherlands-Flanders, Croatia, Slovenia, Greece, Israel, Uganda, India, and Singapore. Soon, France, francophone Switzerland, and Serbia will hold their inaugural meetings. ISPS has sponsored the publication of six books; publishes a regular newsletter; and is about to launch its own, peer-reviewed journal: *Psychosis: Psychological, Social and Integrative Approaches* (ISPS, 2007). It has become interdisciplinary and has expanded from a predominantly psychoanalytic perspective to support "treatments that include individual, family, group and network approaches and treatment methods that are derived from psychoanalysis, cognitive-behavioural, systemic and psycho-educational approaches" (ISPS, 2007). "Survivors," clients, patients, and interested others are welcome as full contributing members.

A main thrust of ISPS's work is to educate mental health professions and the general public that schizophrenia is not a "hopeless" condition that is unresponsive to treatment, a position first promulgated in the early 20th century by Emil Kraepelin (Campbell, 2005). A recent argument against Kraepelin's position is presented on the ISPS-US web site in a posting by Brian Koehler (Koehler, 2006). Primarily summarizing information from "Beyond Dementia Praecox: Findings from Long-Term Follow-Up Studies of Schizophrenia" by Joseph Calabrese and Patrick Corrigan (2005), Koehler presents the outcome results of 10 long-term studies involving a sample of over 4,000 schizophrenic patients from both developed and developing countries. On average, roughly 50% of these individuals showed either partial or full recovery from their disorder. While medication is an element in the improvement of schizophrenic individuals, Koehler cites Harding and Zahniser's (1994) assessment of similar, long-term follow-up literature and their judgment that at least 25% to 50% of the participants in these studies were completely off medications, experienced no further symptoms of schizophrenia, and were functioning well. In this regard, it is relevant to cite the theme of Harding and Zahniser's review, titled, "Empirical Correction of Seven Myths about Schizophrenia with Implications for Treatment." The article presents empirical evidence accumulated across the last 2 decades to challenge "a number of long-held myths in psychiatry about schizophrenia (SCZ), . . . [including] (1) once a SCZ person always a SCZ person, (2) all SCZ people are the same, (3) rehabilitation can be provided only after stabilization, (4) psychotherapy is useless for SCZ, (5) patients must be on medication all their lives, [and] (6) SCZ people hold only low-level jobs" (p. 140).

In my work with Dr. Karon within the ISPS-US, I have been most impressed by the clinical creativity, sensitivity, and effectiveness of his work with individuals suffering from "schizophrenia," and I am therefore very happy to see the publication of his classic case of Mr. X (Karon, 2008), which, in my view, embodies these qualities. In the case of Mr. X, Karon says, "Schizophrenia...[is] a chronic terror syndrome based on the whole life history, starting in early infancy, as experienced by the patient and on the fantasies, conscious and unconscious, formed

on the basis of actual experiences and earlier fantasies, with which that life was given meaning” (p. 3). From my psychoanalytic perspective, this is the foundation of the ISPS-US orientation. The collection of postings by Brian Koehler (2007) on the ISPU-US web site presents current neurophysiological, genetic, psychodynamic, and philosophical data substantiating this thesis. Our mission is especially important in this “era of the brain,” where almost every advertisement for a psychopharmacological agent begins with the premise, “schizophrenia is a brain disease.” This is not a useful assertion, but sends a message of hopelessness to thousands of people who experience this as a decree that their brains are hopelessly broken, and that they must continue taking medicines which not only dull their emotions, but also significantly impact their life-spans through induction of obesity, diabetes, cardiac instability, and tardive dyskinesia. The physiological abnormalities found in psychosis are found also in other conditions involving chronically high stress, such as the borderline conditions and post-traumatic stress disorder.

We are in a time of crisis. As documented on the web site of the National Association of State Mental Health Program Directors (NASMHPD; 2006), recent data from several states found that people with serious mental illness served by our public mental health systems die, on average, at least 25 years earlier than the general population. On that web site some of the detailed connections between anti-psychotic medications and these death rates, including evidence of worsening outcomes in recent years, are also explored. =

Karon's approach to conducting psychotherapy with schizophrenically disordered individuals emerges from a combined psychodynamic and humanistic orientation. One of the leaders of this paradigm was Frieda Fromm-Reichmann, whose impact strongly pervaded the Chestnut Lodge psychiatric hospital, where I worked for 25 years.^{2, 3} My experience with Karon reminds me of the qualities of Fromm-Reichmann. Both communicate a humble confidence in the ability of the other person to grow stronger and wiser. In response to this, you *want* to improve, to validate their trust in you, whether you are a young clinician or someone struggling with intense psychosis. In Fromm-Reichmann's words:

What, then, are the basic requirements as to the personality and the professional abilities of a psychiatrist? If I were asked to answer this question in one sentence, I would reply, “The psychotherapist must be able to listen.” This does not appear to be a startling statement, but it is intended to be just that. To be able to listen and to gather information from another person in this other person's own right, without reacting along the lines of one's own problems or experiences, of which one may be reminded, perhaps in a disturbing way, is an art of interpersonal exchange which few people are able to practice without special training. To be in command of this art is by no means tantamount to actually being a good

² Chestnut Lodge closed as a hospital in 2001.

³ Fromm-Reichmann died when I was a sophomore in high school, but her spirit imbued all the Chestnut Lodge work, and through my work in organizing the 1985 Chestnut Lodge Symposium, celebrating the 50th anniversary of her arrival there, and then editing *Psychoanalysis and Psychosis* (1989), a festschrift to her that grew from the Symposium, I have come to feel that I have known her. The day after the Symposium, a white dove flew into my backyard, and I cared for her, healing an ulceration under her left wing. She lived in my greenhouse for years, laying infertile eggs; and I felt she was a thank-you gift from Fromm-Reichmann.

psychiatrist, but it is the prerequisite of all intensive psychotherapy. (Fromm-Reichmann, 1950, p. 7)

My colleague at Chestnut Lodge, Bertram Nayfack, conducted a retrospective chart review of treatments conducted during the years 1950-1975, the years included in Thomas McGlashan's Chestnut Lodge Follow-Up Study (McGlashan, 1984, 1986a, 1986b). Nayfack investigated the treatment results in the study by therapists, teasing out the features in the therapists that led to positive outcomes, and those of therapists who did not have such successful outcomes. Unfortunately, Nayfack's report was never published. His analysis showed that if the therapist was respectful, had an optimistic outlook for the patient, and eschewed sarcasm or the forcing of his or her expectations onto the patient, and if the therapist had a warm sense of humor, the therapist's patients fared far better than those of a demanding, easily frustrated and sometimes hostile therapist. =

Bert Karon speaks as if he had studied for years with Frieda Fromm-Reichmann and Harry Stack Sullivan, and yet, ironically, I do not believe he ever heard either of these great therapists present a paper. I suspect that their paths did not cross because in the United States in the Fromm-Reichmann and Sullivan era and beyond, since as Karon (2008) vividly illustrates in the case of Mr. X about this issue, the chasm was tragically wide between the M.D. and the Ph.D. worlds, due mainly to the efforts of those in the American Psychoanalytic Association to maintain psychoanalysis as a medical specialty, opposing any encouragement of "lay analysis."

As a psychiatrist, I was happy to counter this chasm a bit, when the Frieda Fromm-Reichmann Memorial Lectureship committee honored Dr. Karon as the Washington School of Psychiatry's Frieda Fromm-Reichmann Lecturer, in 2001. The aim of this series, which began soon after Fromm-Reichmann's death in 1957, was to bring speakers to the School whose work dovetailed with that of Fromm-Reichmann (Fromm-Reichmann, 1950; Greenberg, 1964; Silver, 1989; Hornstein, 2000). Karon began his lecture,

No one who read Frieda Fromm-Reichmann's (1939) paper, "Transference Problems in Schizophrenia," could reasonably think about persons with schizophrenia in the same way as before. As her writings made clear, schizophrenia is a human experience with meaning, meaning that is hard to uncover, but it only takes patience, kindness, a tolerance for not understanding, a willingness to understand the human condition at its most painful, a tolerance for desperate defenses, and a willingness to take psychoanalytic ideas seriously when patients talk about them. Understanding persons with schizophrenia means facing facts about ourselves, our families, and our society that we do not want to know, or to know again (in the case of repressed feelings and experiences). (Karon, 2003, p. 90)

In her article cited earlier, Fromm-Reichmann (1950) refers to Sándor Ferenczi's (1931) paper, "Stages in the Development of the Sense of Reality," thereby moving us back to a founder of psychoanalytic applications to the treatment of psychotic states. Ferenczi said,

I have had a kind of fanatical belief in the efficacy of depth-psychology, and this has led me to attribute occasional failures not so much to the patient's "incurability" as to our own lack

of skill, a supposition which necessarily led me to try altering the usual technique in severe cases with which it proved unable to cope successfully. It is thus only with the utmost reluctance that I ever bring myself to give up even the most obstinate case, and I have come to be a specialist in peculiarly difficult cases, with which I go on for very many years. (Ferenczi, 1931, p. 128)

Ferenczi saw the great potential value in studying one's countertransferential responses to one's patient, moment-by-moment (Silver, 1993). He even experimented with mutual analysis (i.e., involving both the patient and the psychoanalyst) when the work seemed stuck, on the assumption that the patient had the most to gain by the analyst's becoming aware of his own resistances and their bases. Ferenczi wrote in his *Clinical Diary* that

No analysis can succeed if we do not succeed in really loving the patient. Every patient has the right to be regarded and cared for as an ill-treated, unhappy child. So it points to a weakness in the analyst's own psychic organization if he treats a patient he finds sympathetic better than the antipathetic one. It is equally wrong to respond to fluctuations in the patient's behavior with fluctuations in our own reactions in an uncorrected fashion. But it is no less of an error simply to withdraw from every emotional reaction, be it of a positive or negative kind, and to wait behind the patient's back for the end of the session, unconcerned about his suffering, or concerned only on an intellectual level, and leaving the patient to do all the work of collection and interpretation almost all alone. (Dupont, 1988, pp. 130-131)

THE CASE OF MR. X

Karon (2008) has his own innovative streak in the case of Mr. X: "As is my usual practice, [Mr. X's] wife had one confidential hour with me, and the right to call me at any time thereafter, but our conversations after that first hour were always to be described to the patient" (p. 4). How does this impact the patient's sense of trust in him, at this most fragile point in the relationship? Would I have the nerve to try this system out? And also in the case, Karon notes:

The patient, too, had the right to telephone me at any time. If he did not reach me, he was to phone an hour later. If that did not reach me, phone an hour later. He was to continue until he reached me...Even if it was two in the morning, he knew that I had been home less than an hour, so he was not disturbing me. (p. 4)

Karon's watchword is: "The therapist must create a therapeutic alliance by becoming unequivocally helpful, tolerating incoherence, tolerating not understanding, and being realistically optimistic" (p. 4). And he adds that the therapist must avoid being ambiguous: "The therapist should try to be unambiguously helpful; the blank screen will inevitably become a monster" (p. 9). Karon tells Mr. X in the first session that "I would not kill him or let anyone else kill him (p. 7)." In my view, to say this takes daring that I find beyond my capability. It feels to me like joining the patient in a sense of omnipotence. But in Karon's hands, as described in Karon's case description, I don't doubt its calming effect. And I was struck by Karon's prescription that his patient tackle his inability to do work-oriented reading by beginning with his

reading an issue of *Playboy*, since Karon saw clearly that this reading inhibition derived from Mr. X's sexual inhibitions.

Overall, Karon is saying that in working with a patient like Mr. X, as you listen and try to interpret psychotic fragments of his speech and thought, those fragments of thought gradually begin to have a meaning, and as you pay attention to those first meanings, other aspects of what a client like Mr. X is saying and doing begin to fall into place, and make sense. In Karon's summary, "As you deal with those fragments that make sense, more and more of what the patient says makes more sense" (p. 5). And, of course, as the patient makes more sense, those around him or her will question the original diagnosis of schizophrenia – if the patient is recovering, it cannot possibly be recovery from an incurable brain disease.

I believe Ferenczi and Karon would have been close colleagues had they been contemporaries. Karon's love for his patient comes through in every vignette he shares with us. He sees the goodness in Mr. X, senses the efforts he has made to win his parents' admiration and affection, and tries to imagine the terror of having been so cruelly punished (tortured) by his mother. His love comes through in the final sentence of his paper, where he quotes his response to the patient who had sent him an article about his having received an award, twenty years after completion of treatment. Karon answered, "From time to time I have heard from people in your field about your accomplishments and from your students about your teaching, and it has always been a source of satisfaction that I was available when you needed me" (p. 23).

I am left very curious about Mr. X's parents' childhoods, and the hardships their own parents had endured. I suspect there were unspeakable agonies in his lineage that culminated in his psychosis, in line with the work of Davoine and Gaudillière (2004). Mr. X's area of expertise is left a mystery. (I am hoping he is perhaps an historian because this would validate the clinical experience of many of us in ISPS that people choose a career path in the hopes of solving the riddles of their own and their family's stories from the past and to correct the wrongs done them, whether they are conscious of that goal or not.)

Regarding how personal traumas are dealt with in the psychoanalytic process, Ferenczi felt strongly that the so-called "classical" psychoanalytic approach was often counterproductive, allowing the analyst to hide his or her own negative emotional responses to the patient, and in hiding them, avoiding exploring with the patient the shared roots of these reactions, which will be unique in each case. This is what led Ferenczi to try mutual analysis, when the analysis of the patient got stuck. The patient was in the best position to help the analyst dig for the roots of his associations to the disliked feature in the patient, since the patient had the most to gain by bringing this unconscious connection into consciousness. In Ferenczi's words,

The analytic situation — i.e. the [analyst's] restrained coolness, the professional hypocrisy [hiding] and — hidden behind it but never revealed — a dislike of the patient which, nevertheless, he [the analyst] felt in all his being — such a situation was not essentially different from that which in his [the patient's] childhood had led to the illness. When, in addition to the strain caused by this analytical situation, we imposed on the patient the

further burden of reproducing the original trauma, we created a situation that was indeed unbearable. Small wonder that our effort [sometimes] produced no better results than the original trauma. The setting free of his [the patient's] critical feelings, the willingness on our part to admit our mistakes and the honest endeavour to avoid them in future, all these go to create in the patient a confidence in the analyst. *It is this confidence that establishes the contrast between the present and the unbearable traumatogenic past*, the contrast which is absolutely necessary for the patient in order to enable him to re-experience the past no longer as hallucinatory reproduction but as an objective memory. (Ferenczi, 1933, p. 159, italics in original)

THE POLITICS OF TREATING SCHIZOPHRENICS: "SEEKING A PORT IN THE STORM"

In Karon's (2008) case of Mr. X, he describes in some detail the conflict between his advocacy of the psychoanalytic treatment for Mr. X, on the one hand, and, on the other, establishment psychiatrists who strongly resisted this advocacy and recommended medication and electro-convulsive therapy only for Mr. X., for whom they foresaw a very poor prognosis. In recent years, this antagonism to the psychoanalytic treatment for individuals disordered with schizophrenia has been led by the U.S. pharmaceutical industry and the American Psychiatric Association (APA). Specifically, APA's original report of the "Schizophrenia Patient Outcomes Research Team" (PORT; Lehman et al., 1998) made the following "Recommendation 22:" "Individual and group psychotherapies adhering to a psychodynamic model (defined as therapies that use interpretation of unconscious material and focus on transference and regression) should not be used in the treatment of persons with schizophrenia." This was a "level C" recommendation, by which they meant there were no scientific data supporting the recommendation, only the opinion of unnamed "experts."

Karon's (2003) Fromm-Reichmann Lecture, mentioned above, appeared in a Special Issue of *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, which I had the honor to co-edit with Tor K. Larsen (Silver & Larsen, 2003). This issue, "The Schizophrenic Person and the Benefits of the Psychotherapies: Seeking a PORT in the Storm," was part of ISPS's effort to put pressure on the members of the PORT Team to consider the removal of the problematic, anti-psychodynamic "Recommendation 22." As a result of its various efforts, ISPS had a partial victory, in that this recommendation was deleted from the revised PORT Report (Lehman et al., 2004). As "evidence-based" methods – whose type of "evidence" is viewed by many in the psychoanalytic community as substantially limited, if not problematic – become endorsed and other methods are ruled inappropriate, we run a considerable risk of being accused of malpractice if we practice "outside the standards of the community." As bizarre as it seems, there seems to be a real professional risk to listening carefully to a person struggling with psychosis, and staying with him or her as long as it takes, until the person's life has become so rich, and his or her anxiety so consistently manageable, that the patient chooses to discontinue the therapeutic relationship. Moreover, as the psychiatric community becomes aware of the devastating physiological effects of our current psychopharmaceutical products, as

detailed in the NASMHPD report (2006) mentioned above, this community is renewing their interest in psychotherapy for all the mental disorders.

On the other hand, it is crucial for the psychodynamic community to develop evidence-collecting methods it considers appropriate for assessing the effectiveness of psychoanalytic therapy with schizophrenically disordered individuals, and to formally and regularly apply these methods to such individual cases receiving psychoanalytic treatment. One such promising method is the pragmatic case study model embodied in this *PCSP* journal (e.g., Fishman, 2005), and dramatically exemplified by Karon's (2008) case of Mr. X.

Obviously, we have a continuing struggle for recognition of our ongoing work and for a more general acceptance of this approach, which is very often praised by recovered patients as having been crucial to their personal success in resuming a happy and productive life. To further promote the scholarship-and-research-based advocacy of psychodynamic treatments, recently T.K. Larsen was appointed Editor-in-Chief of the forthcoming journal of the ISPS, *Psychosis: Psychological, Social and Integrative Approaches*, which will be published by Routledge beginning in 2009.

CONCLUSION

We are in a struggle to keep humanism strongly in place in the treatment of psychotic disorders. If you find Bert Karon's paper helpful and inspiring, please consider joining ISPS, adding your voice to our listserv discussions, and meeting us in person at our annual meetings. And if you have not yet discovered Robert Whitaker's *Mad in America*, please consider reading it, for an extremely insightful and meticulously researched review of the history of psychiatry in the United States and its deeply discouraging pattern of looking for quick fixes to the problem of psychosis, these approaches each time causing great harm to the sufferers, while providing supposedly scientific rationales for avoiding intensive and in-depth relationships with the sufferers. A sense of Whitaker's book is captured with this quote from a review of it by *Publisher's Weekly* (2002), reminding us of the battle in which ISPS is engaged in fighting for proper psychotherapeutic treatment of schizophrenia:

Tooth removal. Bloodletting. Spinning. Ice-water baths. Electroshock therapy. These are only a few of the horrifying treatments for mental illness readers encounter in this accessible history of Western attitudes toward insanity. Whitaker, a medical writer and Pulitzer Prize finalist, argues that mental asylums in the U.S. have been run largely as "places of confinement facilities that served to segregate the misfits from society rather than as hospitals that provided medical care." His evidence is at times frightening, especially when he compares U.S. physicians' treatments of the mentally ill to medical experiments and sterilizations in Nazi Germany. Eugenicist attitudes, Whitaker argues, profoundly shaped American medicine in the first half of the 20th century, resulting in forced sterilization and other cruel treatments. Between 1907 and 1927, roughly 8,000 eugenic sterilizations were performed, while 10,000 mentally ill Americans were lobotomized in the years 1950 and 1951 alone. As late as 1933, there were no states in which insane people could legally get married. . . . Whitaker's book . . . will appeal to those interested in medical history, as well

as anyone fascinated by Western culture's obsessive need to define and subdue the mentally ill. (quoted from Amazon.com, 2007, p. 1)

Once you have read Whitaker, track down a copy of Karon and VandenBos's (1981), *Psychotherapy of Schizophrenia: The Treatment of Choice*. If you are not convinced, please come and debate with us.

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