

Response to Commentaries on An "Incurable" Schizophrenic: The Case of Mr. X

Psychotherapy of Schizophrenia Works

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ABSTRACT

Davidson (2008), VandenBos (2008), and Silver (2008), well-known experts in the treatment of schizophrenia, have provided very interesting, thought-provoking, and important perspectives on my Case of Mr. X (Karon, 2008) and other such patients. In my response to Davidson, I describe my own problematic clinical experience concerning his positive view of “assertive community treatment.” I also reply to the questions Davidson raises about my clinical techniques and interpretations, e.g., my telling Mr. X that I would not let anyone kill him, my telling Mr. X that he would not become psychotic again under the normal stresses of life, and my interpretation that Mr. X’s not eating was the result of the fear of being poisoned. Finally, I provide an alternative interpretation from Davidson of Freud’s case of the Wolf Man. Because VandenBos and Silver are longtime, supportive colleagues and collaborators, I spend most of my time in responding to their commentaries by emphasizing our points of agreement. Throughout this response, I emphasize my belief that that the powerful ideas in psychoanalysis are not just abstractions, but rather the source of strategies that are very pragmatically helpful in conducting psychotherapy with individuals suffering from schizophrenia. -

Key words: schizophrenia; psychoanalysis; “Wolf-Man”

It is a very good feeling to have one’s contribution discussed by three very bright, knowledgeable, and constructive colleagues, each of whom has made valuable contributions of their own. I will discuss each in turn.

Larry Davison

Larry Davidson, whom I do not know, has made many humane and scientifically supported contributions to the treatment and rehabilitation of psychotic individuals, which have clearly made a difference in the real-world lives of these patients, who are so often mistreated, neglected, or given treatments that do more harm than good. “Assertive community treatment” (“ACT”) as he describes it is kindly and effective.

But, in the real world, the same words are often used with very different meanings. In Michigan, “assertive community treatment” frequently is simply a synonym for forced medication, without meaningful psychotherapy, counseling, or rehabilitation. As one patient told me, he had given the local Community Health Center his address, because his girlfriend, who was also schizophrenic, sometimes spent the night with him. He thought he was helping her, until there was a knock on the door, and two policeman and an attendant came in, seized her, and gave her a shot of Prolixin, and this was repeated without regard to her concerns with side effects (tardive dyskinesia seemed to be beginning), or requests for therapy. It also meant that when he moved out of state, she was forbidden to go with him or visit him, on pain of being jailed, lest she avoid her shots. She was told she had the right to go to court to change her status, but she could not afford a lawyer.

Like Dr. Davidson, I too trust the survivor/consumer movement as the source of the most relevant information. For example, I am most impressed by the recent decision of the Supreme Court of the state of Alaska, in a case brought by the lawyer James Gottstein (2007), on behalf of the Law Project for Psychiatric Rights, which reaffirmed that professionals must use the least restrictive alternative in treating psychiatric patients.

Dr. Davidson raises some interesting theoretical issues. He was understandably surprised (as was Dr. Silver) at my saying to the patient that I would not let anyone kill him. This is not derived from psychoanalytic theory, but rather drawn from what patients have told me. They usually feel that they are in danger of being killed by omnipotent forces or people, conclusions that you and I would recognize as intrapsychic in origin. Who but a therapist could save them from such dangers? They are relieved by a semi-magical, seemingly omnipotent reassurance to offset their helplessness in the face of omnipotent dangers. Professionals who have observed me interviewing new patients have said that they were not sure anything I said made sense to the patient, but they usually noticed that the patient reacted positively to this reassurance. Sometimes the professionals have said that they forgot to tell me that the patient was afraid of being killed. How did I know? The answer, of course, is that all schizophrenics are afraid of being killed. Of course, there are real dangers that you cannot save the patients from. My inner-city patients, for example, knew much better than I did how to survive the real violence of the unsafe areas of the city in which they lived; but that was not what they were afraid of. If you do use such semi-magical techniques, you should be uncomfortable with them, and abandon them when the patient no longer needs magical protection. It is not unusual for the patient to be amused at the fact that they actually believed that you had magical powers, when they needed it, now that they feel it is safe to be realistic, which may be in a matter of weeks or in a long time.

Dr. Davidson is also surprised by and feels that one cannot make the kind of reassuring statement that I made, namely, that under the normal stresses of life Mr. X would never be psychotic again. I said that because, in my best judgment, it was true. It was a clinical judgment, not a theoretical statement. (The contrary statement, however, would have been a theoretical statement based on the mistaken theory that the patient’s problems were due to an incurable biological disease.) Indeed, the rest of Mr. X’s life proved that it was true. One of the differences between our experiences may be that Dr. Davidson frequently talks to patients who

are on medication. I have never had a patient still on medication to whom I would make that statement.

Dr. Davidson suggests, correctly, that not eating, like any other symptom, may have many different meanings. But psychotic patients have taught me that for them not eating is usually the result of the fear of being poisoned (Karon, 1960), which in turn is related to their mother's reactions after feeding them throughout life from infancy onwards. (In addition to reconstructions from therapy, I was actually able to observe, and have others observe, the mother's reactions, of which she was unaware, over a period of time in one such case, as was described in that paper [Karon, 1960].) I have also written that the psychotherapy of patients who do not eat is best carried out by having a meal with the patient and talking about the problems in that context, as I did in this case. Since schizophrenics frequently do not tell you what is going on, not even what they consciously know, since they are afraid it may be used against them, it is reasonable to use clinical experience for a good clinical guess when you are trying to cope with a symptom, such as not eating, which can have serious consequences.

Dr. Davidson again notes that some of the problems in Mr. X's family can be found in other families where the resultant symptoms are not that severe. In this he is correct. Schizophrenics are not different from the rest of us; their problems would (or do) bother us. What is different is the pervasiveness of the problems or the severity of the problems or the lack of corrective experiences with people outside the family. It has long been noted that families of patients who become schizophrenic often discourage relations with peers and adults outside the family, inadvertently removing one of the normal corrective factors that most of us use to cope with and greatly diminish the bad effects of the mistakes every parent makes. Moreover, Thematic Apperception Test (TAT) studies of unconsciously based hurtful parenting find that parents of schizophrenics tend to be more consistently unhelpful than other parents, without being aware of it (Karon & Widener, 1994).

While it is a little tangential, Dr. Davidson raises the interesting case of the "Wolf-Man" (so called because of a dream involving wolves) treated by Freud (Gardiner, 1971). This case is often referred to by critics of psychoanalysis, since Freud claimed to have helped the patient with psychoanalysis, but the patient broke down twice more. The man was originally treated as an in-patient by Kraepelin, who diagnosed him as a manic-depressive. Among his symptoms were sudden depressions, for which the patient had no explanation or clearly made up explanations, and sudden elations, for which the patient had no explanation or clearly made up explanations. The patient's father had been diagnosed as a manic-depressive, which for Kraepelin proved the diagnosis was correct.

According to the patient, he was impressed with Freud because Freud was the first psychiatrist he ever talked to who said his interest in women was healthy. He told Freud that he had fallen in love with a nurse at Kraepelin's hospital, and when she said she would have nothing to do with him because she would get fired, he was depressed. When she showed an interest in him, he was elated. Of course, he could not tell Kraepelin about it, because Kraepelin would fire her.

Freud told him that this woman sounded like a very nice person, but if he were serious about her, he owed it to her to get his problems straightened out before marrying her. That made good sense to the patient, and he went into treatment with Freud and was helped.

The patient was a Russian and a multi-millionaire. But an extraordinary event occurred – the Russian revolution. Most of his close relatives were killed, and the patient lost all his money. He had never conceived of the possibility that he would ever have to work for a living. That is when he broke down again. He wanted to go to Russia to try to retrieve his fortune, but Freud told him not to go, he had something much more valuable than his fortune to lose. Freud treated him again. Indeed, Freud gave him money to live on, since he did not know how to earn a living. (Apparently, Freud never considered kindness an impermissible breach of technique.) After this second treatment, he not only lost his other symptoms, he was able to get a stable job and successfully earn a living.

But he broke down a third time when the Nazis took over Austria. His wife, whom he deeply loved, was part Jewish. Knowing what the Nazis meant to do to the Jews, she killed herself. The loss of his wife under such tragic circumstances precipitated his third break down. Analysis, this time with a student of Freud's, helped him again.

Thus, he did break down twice after successful treatment. But that was not under the stress of normal life. To interpret breakdowns in the face of overwhelming catastrophes as evidence of a failure of treatment is certainly unwarranted.

In short, psychotherapy works. It helps severely disturbed people, including schizophrenics. The tragedy is we do not make it available.

Gary VandenBos

Gary VandenBos is an old friend and former student who is an excellent clinician himself, who has worked with very severely disturbed patients, who has trained others to work with severely disturbed patients, and who has done valuable research on the appropriate treatment of difficult patients. He understands the way I think better than anyone. We do not always agree, and he has taught me many valuable insights about treating patients. At a time when I found myself drifting toward the abstract kind of work emphasized in academic settings and not the clinically relevant papers that I value more highly, he and I collaborated on a clinical paper of which I am still particularly proud on how to be helpful to economically poor patients (Karon & VandenBos, 1977). Along with this, Dr. Vandenbos collaborated with me on my most important work, the book *Psychotherapy of schizophrenia: The treatment of choice* (1981), which contained both clinical insights and rigorous empirical research.

Dr. VandenBos lists the 10 most common negative reactions he has received from professional audiences when he presents on the process of doing psychotherapy with schizophrenics. I find his exposition of these accurate and his discussion of them insightful. Perhaps most important is his discussion of reaction 8, "It Sounds Too Easy," where he corrects a false impression that one can easily have from my truncated discussion. Vandenbos writes:

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 behavior and symptoms) provided me with the clues that I was 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. (p. 41)

It is easy to believe that he or I (or any psychoanalytic therapist) impose a theory on the patient, rather than listening carefully, considering many possibilities, and honing in on what seems to be true for the individual patient. It is true that being silent may be perceived by these patients as rejection, so it is important to try to say something relevant. But at every stage there is much more uncertainty as to what to say, and one considers many more possibilities than is obvious to an external observer. Of course, schizophrenics may not trust you enough to tell you what is relevant, and you may have to make your best clinical guess, given what is available, based on previous experience, or even theory. But you always correct it on the basis of the further material the patient provides. The truth is never in theory, but in what the patient says. Further, even if you are wrong and misunderstand, the patient reacts positively to the fact that you are clearly doing your damndest to try to understand them. Research has shown that patients often report feeling understood when the therapist does not actually understand them correctly, but clearly has been trying very hard to understand them. This is not surprising since when, except in good therapy, do we have a bright, kind, intelligent person trying to make sense out of our lives and experience no matter how awful, confusing, or frightening those experiences might be, or how angry, uncommunicative, or uncooperative we act.

Dr. VandenBos is right that the treatment he and I conduct is not psychoanalysis by many current definitions. But I prefer Freud's definition that any investigation which takes seriously four concepts is psychoanalysis, even if it disagreed with him in every other respect. The four concepts were the unconscious (that there are thoughts, feelings, memories, and wishes that are real but not available to consciousness); repression (that some things are unconscious because they are painful); resistance (that patients unconsciously try to keep unconscious material unconscious, and the resistances are the same defense mechanisms they use in the rest of their life being used in the therapy hour); and transference (that patients repeat memories and feelings from the past without awareness that it is the past and not the present).

Ann-Louise Silver

Ann-Louise Silver is someone who has done more to keep alive, improve, and expand humane and effective treatments for schizophrenia than any other professional I know of in the United States. Her contributions include not only her own professional work with schizophrenic patients and her insightful writings which real therapists find helpful, but also her willingness, when elected by her colleagues, to serve as President of the United States Chapter of the International Society for the Psychological Treatments of Schizophrenia and Other Psychoses (ISPS-US). Under her leadership this organization has become one of the most constructive groups of professionals in our field. Her only failing, according to most of her colleagues, has been her unwillingness to continue in that role forever. Whatever she has to say deserves to be paid careful attention.

It is noteworthy that at the meetings of ISPS-US, professionals of different theoretical orientations who actually work with patients understand each other. They may not use the same abstractions, and they may not solve problems in the same way, but they know what the problems are that the other therapists are trying to solve. This is very different from professionals who only talk or write about therapy but do not actually do the work.

At the ISPS-US meetings, there is the opportunity to learn what happens when other therapists work in a way different from your own. Thus, for example, therapists who never medicate, who always medicate, who begin patients on medication and withdraw them, who use medication only for crises, or who maintain patients on medication forever can and do share their observations of what actually happens. That kind of useful mutual exchange of information occurs for every difficult decision in the treatment process.

Dr. Silver mentions that I was never lucky enough to study with Sullivan and Fromm-Reichmann in person, which is true, but I was lucky enough to study with Sullivan and Fromm-Reichmann and Freud and Ferenczi and Fairbairn through their writings, and each of them influenced me more than anyone I have ever met in person. It is exciting to learn new ideas that powerfully change your understanding of the human condition and that make it possible to palpably change patients for the better. It was Dr. Silver, as well as Drs. Brian Koehler and Johanna Tabin, who encouraged me to complete for ISPS-US the paper, "Abstractions, the Psychoanalyst's Defense Against Psychoanalysis: Ferenczi's 'For Example' Revisited" (Karon, 2003). Here I was able to discuss a conclusion that I had held for some time, namely, that the powerful ideas in psychoanalysis are not just abstractions, but the source of strategies that are very pragmatically helpful in the conduct of the therapy.

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