

# The Tragedy of Schizophrenia without Psychotherapy

Bertram P. Karon

**Abstract:** No one who read Frieda Fromm-Reichmann's "Transference Problems in Schizophrenia" could reasonably think about persons with schizophrenia in the same way as before. Her writings made clear that schizophrenia is a human experience with meaning, meaning that is hard to uncover, but it only takes patience, kindness, a tolerance for not understanding as well as for the patient's desperate defenses, and a willingness to understand the human condition at its most painful and 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).

Families and professionals are settling for treatments that aim at making the patient a lifelong cripple who is not too disturbing. Psychoeducational programs, which potentially could be helpful, usually give false information which makes worse the burdens of both patients and their families. The ultimate genetic experiment, the Nazi sterilization and annihilation of patients, led to no decrease in schizophrenia in the next generation. Long-term follow-up studies show one third of schizophrenics fully recover within 25 years and another third have social recoveries with or without treatment—and psychological treatments before the neuroleptic era, from "moral treatment" to psychoanalytic therapies, produced superior results, but we are not using them. The central role of terror in producing symptoms and the genesis and psychotherapeutic handling of symptoms, including delusions and hallucinations, will be described.

**Key words:** schizophrenia; psychotherapy; psychoanalysis; psychosis; treatment

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The author wishes to thank Leighton C. Whitaker, Ph.D., Gary R. VandenBos, Ph.D., Michael Teixeira, Ph.D., and Anmarie Widener, M.A., M.S.W., all of whom have influenced the content of this article.

Presented as the 2001 Frieda Fromm-Reichmann Lecture at the Washington School of Psychiatry, March 30, 2001.

Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry, 31(1), 89-118, 2003  
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## INTRODUCTION

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).

Freud (1917) thought that persons with schizophrenia could not be treated for both theoretical and clinical reasons. His theory of libido as a substance or energy, combined with his theory of narcissism as libido turned toward the self, suggested that schizophrenics could not form a transference. Nonetheless, he thought of this as a problem that someone might solve. Clinically, however, Freud said schizophrenics scared him (Richard Sterba, personal communication), but even Freud did not have much insight into people he did not treat. Many of the symptoms of schizophrenia are simply transference to the world at large; the problem is not how to form a transference, but how to form a therapeutically usable transference as discussed below.

The real tragedy of schizophrenia is not the severity of the symptoms and the suffering that results for patients and for their families, but that we know psychoanalytic therapies that work and we are not using them. Families and patients are settling for treatments that aim at making the patient a lifelong cripple who is not too disturbing. Psychoeducational programs, which could be helpful, usually give false information which makes worse the burdens of both patients and their families.

The best description of what it feels like to be schizophrenic came from a catatonic man for whom it took eight weeks of psychotherapy (without medication), five days per week, to get out of the hospital and back to work. One of his symptoms was bowing. When asked why he bowed, he said, "I don't bow."

"Yes, you do."

"No, I don't bow."

"Wait a minute. You do this [the therapist bowed]. This is bowing; you bow."

"No, I don't bow."

"But you do this."

"That's not bowing."

"What is it?"

"It's balancing."

"What are you balancing?"

"Emotions."

"What emotions?"

"Fear and loneliness."

That is, when he was lonely, he wanted to get close to people (so he leaned forward). When he got close to people, he got scared and had to pull away (so he straightened up). But then he was lonely again. Balancing between fear and loneliness is the best description of what it feels like to be schizophrenic. But that is what the rest of us, professionals and nonprofessionals alike, do not want to understand.

The most important research findings on schizophrenia in the last 20 years are the long-term follow-up studies. Kraepelin (1907), Eugen Bleuler (1911), and Manfred Bleuler (1971, 1978) taught that schizophrenia was a chronic disorder with possible remissions, but that its course was poor in the long run. But as Manfred Bleuler pointed out, they were misled because they followed only hospitalized and rehospitalized patients. When Ciompi (1980) published 40-year follow-up data for patients in Switzerland from 1900 on, the course of schizophrenia was highly variable, seeming more like the vicissitudes of life than the course of one or several diseases. This and the other four studies which followed schizophrenics for more than 25 years, from Switzerland, Germany, and the United States, were summarized in 1987 by Harding, Zubin, and Strauss (1987), who found that 30% fully recovered in the long run, and that 60% to 70% became self-sufficient. There was no change with the introduction of modern medications. Moreover, re-diagnosing the patients using DSM-III diagnoses (American Psychiatric Association, 1980), which are essentially the same as DSM-IV (American Psychiatric Association, 1994), in place of earlier diagnostic criteria made no difference in predicting the long-term outcomes in Harding's own 32-year follow-up study.

Harding (1988) pointed out that professionals who encourage patients to take their medication are well-meaning, but in her own follow-up study all of the patients who fully recovered were among the 50% who had stopped taking their medication. This could mean either that the healthier patients feel freer to stop, despite their doctor's advice, or that the medication, helpful in the short run, prevents full recovery, or both.

More recently, Harding (1995) has summarized five more studies, for a total of ten, with somewhat more variability, leading to the conservative recommendation that professionals tell patients and families: "You

have a serious illness but results from ten worldwide studies show that you have a 50–50 or better chance of significant improvement and perhaps recovery” (p. 672).

Nonetheless, DSM-IV (American Psychiatric Association, 1994, p. 282) states that “Complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder.” This contradicts the findings of every long-term follow-up study, as well as denying that patients have recovered with appropriate psychotherapy. Professionals continue to tell patients and their families that schizophrenic patients will never get better, robbing them of hope. Patients are advised never to have children. But as Manfred Bleuler first reported (1978), the data are that 80% of children of schizophrenics raised by their schizophrenic parent never become schizophrenic. Further, the 20% rate of schizophrenia can be lowered by preventive counselling (Bleuler, 1978).

At the end of the 18th century, before modern psychotherapy or modern medication, Phillipe Pinel and the other practitioners of moral treatment innovated treatments that worked, contradicting the earlier myth of incurability (Bockoven, 1972). In France, England, Scotland, and the United States, moral treatment produced startling results: 60–80% of patients were discharged. Its elements were simple: First, use no cruelty or humiliation. Use physical force only to prevent the patient from harming him or herself or others, but not for punishment. Second, get as accurate a case history as possible. Third, encourage work and social relations. Finally, and most powerfully and seemingly unscientific—do your best to understand the patient as an individual human being. Based on the records of hospitals that continued to exist, the results of moral treatment were better than the results obtained from the middle of the 19th century to the beginning of the 20th century when moral treatment had been abandoned and discharge rates dropped to 20–30%.

Moral treatment was succeeded by physical treatments whose proponents claimed to be more scientific. These treatments did not require understanding the patient and had economic advantages for the public sector. The ensuing myth of incurability was reassuring (Alexander and Selesnick, 1966; Bockoven, 1972; Whitaker, 1992).

But Eugen Bleuler noted that when he read Freud and applied psychoanalytic ideas to his patients at Burghölzli, three times as many were discharged (Federn, 1943). By the middle of the 20th century psychodynamic psychotherapies were developed, most of which were based on the work of Fromm-Reichmann and Sullivan. During the period when psychoanalytic therapies were most frequently used, patients benefited. Comprehensive surveys of outcome studies in the United States show

28% favorable outcome before 1925; 49% from 1956 to 1986 when psychotherapy was most likely to be offered; and 36% from 1986 to 1994 (Hegarty et al., 1994).

Today psychotherapies have largely been abandoned, the patients have stopped getting better, and psychotherapies have been succeeded by physical treatments that claim to be more scientific, which do not require understanding the patients and which have economic advantages for everyone except the patients. And the myth of incurability has been re-created.

In the 1930s Frieda Fromm-Reichmann and Harry Stack Sullivan consistently helped schizophrenics. While they made use of psychoanalytic and interpersonal theoretical constructs, they discarded the concept of libido. Consequently, there was no theoretical reason why schizophrenics could not be treated. The treatment was arduous, but patients improved (Fromm-Reichmann, 1950; Sullivan, 1953). The well-known novel, *I Never Promised You a Rose Garden* (Greenberg, 1964), described that early treatment. The author had been a patient of Fromm-Reichmann. This book, as well as her other novels, demonstrates the kind of recovery that allowed the patient to write so well.

To understand schizophrenic persons is to grasp painful facts about the human condition that we would rather not know. The sociological data about schizophrenia remind us of unpleasant realities. A disproportionately greater incidence and prevalence of schizophrenic disorders is associated with low socioeconomic status (Hollingshead and Redlich, 1958) which cannot be accounted for by downward drift. While this has been disputed, current data are still consistent (Cohen, 1993). This suggests, and psychotherapeutic experience makes vivid, the physical and psychological pain, humiliation, and physical danger associated with being very poor in our society—realities which those of us who are not very poor do not like to perceive or remember. Similarly, schizophrenic disorders are more common among those who are the victims of prejudice and discrimination (Karon, 1975). The psychotherapist will often be confronted with the ugliness of the economic, racial, ethnic, and religious discrimination which has contributed to these disorders. That the prognosis for schizophrenics is better in nonliterate cultures (Sartorius, Jablensky, and Shapiro, 1978) reminds us of the relative lack of kindness in our “civilization.” Lambo (1957) reminds us that the quicker recovery in Africa is a result of the favorable social environment. (According to R. Whitaker, 2002, not medicating may be an even more important factor.)

Many schizophrenics have talked about incest, sexual abuse, and physical abuse; but such talk nearly always has been dismissed as the ravings of lunatics (Rieger, 1896). Freud, referring specifically to con-

version hysterics, reported that the incest memories they related in psychoanalysis were revealed more often to be fantasies than real events, although in many cases, according to Freud, they were undoubtedly real (Freud, 1917, p. 370). Psychology, psychiatry, and psychoanalysis (but not Freud) falsely generalized that all such memories of all patients were only fantasies, because it was believed incest was a rare event (for example, J. Strachey and Jones as cited by Masson, 1984, p. 213).

Therapists and researchers who worked with schizophrenics (for example, Lidz, 1973), however, reported that the incest "fantasies" related by those patients more often reflected real events rather than fantasies, as did their memories of child abuse. The ugly realities of child abuse—psychological, physical, and sexual (including incest)—in our society are only now evident to most mental health professionals. It is now known, for example, that one out of six women, and perhaps one out of three, have been sexually abused (Finkelhor, 1979; Gagnon, 1965; Russell, 1983).

The fantasies of schizophrenics help to illuminate the fantasies which all people share. Psychotherapeutic work with schizophrenics (Karon and Rosberg, 1958) revealed that they often wish to be their own mother. This wish, consciously or unconsciously, may underlie many symptoms. But Kestenberg (1975), on the basis of her observation and treatment of children, reported that at the age of two years, nearly every child goes through a stage where he or she wants to be a mother. Girls want to be a mother to a little girl, and boys want to be a mother to a little boy, so it is clear whose mother they want to be.

In order to help a postpartum schizophrenic (Rosberg and Karon, 1959), it was necessary to learn (in her psychotherapy) about the fantasy that anything that filled the body was food. But Michel-Hutmacher (1955) found that normal children under seven years regularly reported that belief.

Schizophrenic patients (Karon and Rosberg, 1958; Rosberg and Karon, 1958) revealed clearly the existence of a terrifying fantasy of having the insides of their bodies emptied out and drained, a terror originating in early infancy and augmented or diminished by later experiences. This fantasy takes various symptomatic forms; some male patients fear being emptied or drained through the penis, which is often experienced as more frightening than castration. Thus some patients attempt to cut off their penises as the lesser evil. Knowledge of this fantasy allows the therapist to recognize the subtle evidence of it that occurs in some relatively normal men whose impotence is derived from this fear and, consequently, to help these nonschizophrenic impotent patients as well.

## TERROR

What happens when a therapist talks to a schizophrenic? Usually the therapist feels uncomfortable, depressed, or angry, because the patient does not react the way the therapist wants him or her to react; the patient often does not show the therapist respect. What the therapist knows does not seem to work. But, in addition, the therapist feels scared and is not sure why. It is not an accident that the most illuminating discussions of negative countertransference have come from therapists who have worked with schizophrenics (for example, Searles, 1965).

One of the reasons for these uncomfortable feelings is that these are the patient's feelings. One of the great mistakes, a mistake that even Eugen Bleuler made, is to assume, because schizophrenics look as if they have no feeling, that they have no feelings. In fact, schizophrenic persons have very intense feelings although they may mask or even deny them. The most basic affect is fear, actually terror. Sometimes the therapist may, all too successfully, empathize with the schizophrenic patient's terror and withdraw from the patient.

Human beings are not easily able to tolerate chronic, massive terror. All of the symptoms of schizophrenia may be understood as manifestations of chronic terror or of defenses against terror. Chronic terror tends to mask other feelings. Nonetheless, the schizophrenic frequently experiences, in addition to fear—continuously or intermittently—anger, hopelessness, loneliness, and humiliation. "Inappropriate" affect is usually *socially* inappropriate, not inappropriate to the patient's inner experiences.

If it is believed that schizophrenics have no affect, then it becomes a puzzle why neuroleptic drugs and central nervous system depressants, which greatly diminish affect, should be helpful. But once the centrality of terror in schizophrenia is understood, then their utility makes sense. All the medications that are used to treat schizophrenics damp down the affect system, diminishing the manifestations of fear. (It was a marketing coup to relabel major tranquilizers as "antipsychotic medication," implying that they are as specific and effective for psychosis as vitamin C is for scurvy. Unfortunately, there is no "antipsychotic" medication in that sense.) But someone living with a loss of affect has handicaps in adjusting to life. For example, teenage gangs prey on medicated patients who are unable to be alert and self-defensive.

We do not want to know about schizophrenia because we do not want to feel such intense terror. Given enough stress, all of us have the potential for schizophrenic symptoms; the differences in vulnerability seem

to lie in the quantity and quality of the necessary stress. The severity of the stress is usually determined by its conscious and unconscious meanings. In 1959 Rosberg and I published a description of the specific meanings of giving birth for a woman whose postpartum schizophrenic psychosis lasted for over 12 years before she was successfully treated with psychoanalytic therapy (Rosberg and Karon, 1959).

## DOES PSYCHOTHERAPY HELP?

The myths of the lack of meaning of schizophrenic symptoms, the irrelevance of understanding, and the incurability of schizophrenic disorders are still with us. A psychologist at a state hospital consulted me about some problems in the treatment of a schizophrenic patient who had been hospitalized for 15 years. After a year of hard and insightful psychotherapeutic work by the psychologist, the patient left the hospital. The staff psychiatrist said, "I guess the medication finally took hold."

Deikman and Whitaker (1979) instituted a regimen of almost purely psychological treatment on one "experimental" ward of a psychiatric hospital. Despite dire warnings that their failure to medicate constituted malpractice, their ward program decreased rehospitalization. There were no suicides, suicide attempts, or elopements during the 11 months in which the ward was fully operative. A comparison ward, more fully staffed and using expert psychopharmacology, had three suicides in the same period despite sending its more disturbed patients to a long-term state hospital. Despite its success, the experiment was discontinued and never imitated.

DSM-IV, in addition to preserving the myth of incurability, rationalizes bad treatment. The very same symptom picture is diagnosed as "brief reactive psychosis," "schizophreniform psychosis," or "schizophrenia," solely dependent on whether the patient recovers in less than one month, more than one month but less than six months, or more than six months, irrespective of type or adequacy of treatment (American Psychiatric Association, 1994, pp. 273-304).

In the 1950s, as Senior Clinical Psychologist at a reformatory for male adolescents, I instituted a policy of psychotherapy for all psychotic reactions. Patients had daily psychotherapy sessions without medication for five days before transfer to the state hospital was considered. Psychotherapy was continued at a minimum of one session per week while the patient carried out ordinary activities. During a six-month period, no state hospital transfers for reason of psychosis were necessary. Before and after that six-month period, patients were transferred to a state

hospital, medicated, and averaged two years (in the 1950s) in the hospital before they were returned to the reformatory. But DSM-IV makes that comparison seem irrelevant. According to DSM-IV, as it were, only "brief reactive psychoses" occurred during the six months when psychotherapy was available, whereas before and after that period, the state hospital treated true "schizophrenics" from the same population.

Sometimes it is argued that research shows psychotherapy is not helpful. However, when the Michigan State Psychotherapy Project (Karon and VandenBos, 1981) randomly assigned schizophrenic patients to (a) an average of 70 sessions of psychoanalytic psychotherapy per patient, (b) medication used effectively, or (c) a combination of the two, blind evaluation showed that psychotherapy alone, or with initial medication that was withdrawn as the patients could tolerate it, led to earlier discharge from the hospital, kept the patients out of the hospital, and improved their thought disorders more than medication did, and the patients lived a more human life in a variety of ways. Psychotherapy with maintenance medication was better than medication alone, but not as good in the long run as psychotherapy alone or with initial medication that was withdrawn. Because of the hospitalization and particularly rehospitalization findings, psychotherapy was much less expensive over a four-year period than traditional treatment with medications.

Unfortunately, decision makers do not seem to be interested in saving money over four or more years. During that time, political administrations, hospital, department, or insurance company heads will change. They are more interested in saving money within six months, or, at most, a year or two; and that is unfortunate. Even worse, in this age of managed care, if patients can be denied benefits entirely, or as a result of inadequate treatment lose their job and consequently lose their insurance, the managed care company may consider these economically successful outcomes.

The Michigan study included experienced and inexperienced therapists. The experienced therapists had over ten years of experience in treating schizophrenics with psychoanalytic therapy, were knowledgeable about treating African-American and lower socioeconomic patients (characteristic of most of the inner-city patients in this study), and were considered effective by their colleagues. The inexperienced therapists wanted to learn how to do this kind of therapy, valued their supervisors, were paid for their time, and were given careful training and supervision.

The Michigan study is different in these respects from the widely cited controlled studies conducted in this country (namely, Grinspoon, Ewalt, and Shader, 1972; May, 1968) which found that psychotherapy was not as effective as medication. (Understandably, a drug company widely

distributed free copies of May's book.) While these studies had many methodological flaws, the worst was that they involved so-called "psychotherapists" and "supervisors" neither of whom had ever treated a schizophrenic patient by psychotherapy before. They either had little training in any psychotherapy or had training in treating a different kind of patient with a different kind of therapy, like a psychoanalyst experienced only in treating upper middle class neurotic outpatients on a couch.

The McLean study (Gunderson et al., 1984) is often cited as evidence that dynamic therapy is not useful, since supportive therapy was more helpful in obtaining work. But only 25% of the patients in either group finished treatment and were evaluated; therapists in both groups were not permitted to allow patients to reduce their medication. Most patients simply avoided the study doctors.

My review (Karon, 1989) of all available studies found by a computer search, found that the effectiveness of psychoanalytic therapy is supported by empirical data. Thus, for example, Benedetti and Furlan (1987) reported from Italy and Switzerland a series of 50 severe schizophrenic cases treated with intensive psychoanalytic therapy (2-5 sessions per week) for 3-10 years by supervisees, with very good results in 80% of the cases.

Schindler (1980) in Austria reported that in a ten-year follow-up bifocal family therapy was more effective than medication, using such criteria as working, taking care of children, and relating to a spouse. Revere, Rodeffer, Dawson, and Bigelow (1983) found that psychotherapy led to discharge and employment, as well as improved psychological functioning in 15-year inpatients at St. Elizabeths Hospital, but not in medicated controls.

Alanen (1991) in Finland demonstrated what a real community mental health system providing psychotherapy for psychotics can do. In each community there is a three or four person psychosis team, each of whom has relevant training. At least one of them has training in the appropriate use of each modality—individual psychotherapy, family therapy, and medication. The first session is always a family session to which all members of the family are invited. It begins with the invitation: "Six months ago your son, daughter, husband, wife, father, mother was not psychotic, now they are. Something must have happened. Can you help us try to figure out what might have happened?"

They have developed sensitive theories of which family interventions are most helpful to the designated patient as well as the other members of the family. The treatment team decides which option or combination of options—individual psychotherapy, family therapy, medication, hospitalization—are most likely to be helpful. Treatment is not decided on a na-

tional basis or even a general local policy, nor by diagnostic category. A decision is made for this individual and family for this week, with the difficult clinical decisions shared by mutually respecting colleagues.

Since this system has been in effect, the amount of medication used has decreased as well as the necessity for hospitalization. The data show that it is cheaper than the previous system of American style community treatment emphasizing medication without meaningful psychotherapy. More importantly, the patients are restored to a more human and productive life.

Clinical experience, without control groups, can nonetheless be convincing. Thus, a patient spent many years at the most expensive hospitals in the United States to no avail and had been treated unsuccessfully by electric shock and insulin comas as well as psychotherapy (but not psychotherapy specific to his psychotic symptoms). He had been catatonic for years at his latest hospital. He finally responded to an intensive psychotherapeutic effort (ten hours a day for ten days with two energetic psychologists). Without medication he began to talk, then responded to five day per week therapy with ordinary sessions, and progressed to outpatient therapy (Rosberg and Karon, 1958). A patient who had been psychotic for 16 years responded to two years of inpatient psychotherapy without medication, followed by outpatient psychotherapy; he went on to a successful independent life (one of the few cases where a 30-year follow-up was obtained). A ten-year-old paranoid schizophrenic recovered after three years of therapy for him and his parents, twice a week. His mother was kind enough to inform the therapist when the ex-patient graduated college.

## TREATMENTS WITHOUT UNDERSTANDING

There has never been a lack of treatments that do more harm than good. They have in common that they do not require understanding the human condition. In this light one can grasp why Freud or Sullivan or Fromm-Reichmann never were awarded a Nobel Prize. Instead, the Nobel Prize was presented to the neurosurgeon Egas Moniz, the pioneer of prefrontal lobotomy, who we now know faked some of his data (Valenstein, 1986). Lobotomy allowed one to treat these people without having to understand them at all. It got them so they would not bother anyone.

Electric shock treatment is still practiced despite clear evidence that it, too, produces brain damage (cf. Breggin, 1979, 1997, 1998; Morgan, 1999). (Of course, this is disputed, but the empirical data relevant to the

conclusions that it does or does not produce brain damage are carefully examined in the sources cited.)

Today, medication is the predominant treatment that does not require understanding symptoms of schizophrenia. Medication reduces disturbing affect and some of its immediate consequences; some of the patients' behavior improves; and they become more compliant. This is sometimes very helpful because other people almost always fear schizophrenics. People tend to be cruel when they are afraid. Because cruelty makes schizophrenic people more schizophrenic, there are advantages to making schizophrenic people less frightening.

However, there are problems with psychiatric medication. Breggin's (1983, 1997; Breggin and Cohen, 1999) reviews of the literature on brain-damaging effects of psychiatric medication indicate that the mental health system is creating a population of brain-damaged people. Not only are patients given medication, but they are told they must take the medication for the rest of their lives. There are professionals who think psychotherapy with schizophrenics is finding out why they do not take their medication; but if they are good patients and take the older medications, in the long run at least 40% of them are going to be demonstrably brain-damaged (Breggin, 1990; 1991, pp. 68-91; 1997).

Suddath, Christison, Torrey, Casanova, and Weinberger (1990) studied the brains of 15 pairs of monozygotic twins discordant for schizophrenia, and found more brain abnormalities of unknown origin in the schizophrenic twin as compared to the nonschizophrenic twin. Though they concluded that this could not be due to the medication because the correlations of lifetime medication dosage with measures of brain damage do not reach the conventional 5% level of statistical significance, in fact the data show that they reached the 6% level; the correlations of abnormalities (namely, enlarged ventricles) with lifetime medication dosage were as high as .50 within the schizophrenic twin sample, all of whom had been medicated. The correlations would be higher if the range of lifetime medication dosage were extended downward to 0. Examination of the data reveals that, contrary to the authors' stated conclusions, the findings of brain abnormalities in the schizophrenic twin as compared to the nonschizophrenic twin would disappear if these differences were statistically corrected for medication dosage. In other words, the simplest explanation of their findings is that the medication produced the brain abnormalities.

Enlarged ventricles result from the medication. And, the excess dopamine receptors found in the brains of schizophrenics have been demonstrated by animal studies to be the result of the medications (Porceddu, Giorgi, Ongini, Mele, and Biggio, 1986; Porceddu, Ongini, and Biggio, 1985). A more recent study showed that patients treated with both traditional and

newer neuroleptics had marked brain changes as compared to drug-free patients and healthy volunteers; these brain abnormalities seemed to be medication-induced hypertrophy (Gur et al., 1998).

Some studies (Boczkowski, Zeichner, and DeSanto, 1985; Irwin, Weitzel, and Morgan, 1971; Willcox, Gillan, and Hare, 1965), as well as clinical experience, suggest that up to 60% of patients who are believed to be taking maintenance medication have stopped and lie about it. The medication is unpleasant: Men are often made impotent by it, women often cannot enjoy sex, and the feeling of not having feelings is unpleasant. Patients lie when they stop taking their medication because they have been threatened with hospitalization or shock treatment, or been hospitalized not for any increased symptom, but just for the act of stopping the medication itself.

The current generation of psychiatrists have been trained almost exclusively in treating patients by means of medications and have neglected their training in psychotherapy. Unfortunately, the medications do not live up to their advertisements: they are only partially effective, they habituate, and they have serious side effects (Breggin, 1991; Breggin and Cohen, 1999; Fisher and Greenberg, 1989). Thus as the disadvantages of medication are finally being learned, some psychiatrists are going back to administering shock treatments without considering psychotherapy. If a psychiatrist instead changes from medicating people to practicing psychotherapy, he or she has three problems: (a) psychotherapy is a difficult skill; (b) it requires experiencing all kinds of very unpleasant feelings; and (c) the psychiatrist's income is going to drop dramatically. A study funded by the American Psychiatric Association reported that psychiatrists who practice psychotherapy cannot make much more than \$100,000 per year, but that a practice confined to medication and evaluation will yield \$300,000—certainly a strong incentive (Moran, 1993).

## GENETICS

Psychotherapy has been discouraged by the supposed evidence from adoption studies which claimed there is a strong, genetic basis for schizophrenia. However, the Danish adoption studies conducted by Kety, Wender, and Rosenthal (Kety, Rosenthal, Wender, and Schulsinger, 1968; Wender, Rosenthal, Kety, Schulsinger, and Welner, 1974; Wender, Rosenthal, Zahn, and Kety, 1971) suffer from fatal scientific flaws and misleading reporting, as revealed in the critiques by Lidz, Blatt, and Cook (1981), by Lidz and Blatt (1983), and in the book, *Not in Our Genes*, by Lewontin, Rose, and Kamin (1984). For example,

biological relatives were reported to have higher rates of schizophrenia than adoptive relatives. But the data for biological relatives is inflated by half-siblings of schizophrenics, who had a higher rate of schizophrenia than full siblings or than parents. No genetic model can account for such a finding.

Adoptive parents whose adoptive child became schizophrenic were reported as not different from adoptive parents whose adoptive child did not become schizophrenic, despite the fact that many of the former had been hospitalized for psychiatric disorders. Margaret Singer (Wynne, Singer, and Toohey, 1976) was able to pick out blindly, with absolutely no errors, on the basis of the Rorschach "communication deviance" scores, adoptive parents whose adoptive children became schizophrenic from adoptive parents whose adoptive child did not become schizophrenic. Kety and his associates (Kety, Rosenthal, Wender, and Schulsinger, 1968; Wender, Rosenthal, Kety, Schulsinger, and Welner, 1974; Wender, Rosenthal, Zahn, and Kety, 1971) did not report this. Even though they had sent Singer the data and knew her results, they reported that psychological tests did not differentiate the two groups of adoptive parents.

There is a careful, extensive adoption study from Finland, reported by Tienari (1992). He found that the most potent predictor of schizophrenia in adopted children is "communication deviance" (cf. Wynne and Singer, 1963), measured in the interaction between the adopting parents without the child being present, so it is not a reaction to a disturbed child. Tienari also found that children of schizophrenics are more vulnerable to other disturbing interactions; but that children of normals or of schizophrenics only became schizophrenic in disturbing adoptive families. No study is perfect, and this study included adoptions as late as four years of age in order to parallel the Danish studies. (See also Tienari et al., 1985, for an earlier preliminary report.) But the Tienari data are by far the best available.

The most impressive genetic experiment was one no sane researcher would have carried out (Binder, 1938; Breggin, 1994; Proctor, 1988). For several years all schizophrenics in Nazi Germany were sterilized. Then the annihilation gas chambers were designed by psychiatrists, originally not for Jews, but for mental patients. Hundreds of thousands of schizophrenics were annihilated. But a generation later, the rate of schizophrenia was not affected (see, for example, Haefner and an der Heiden, 1997).

## Life History

Clinical experience also leads one to be skeptical of genetic factors. If one listens carefully to the patient, the disorder always makes psy-

chological sense and seems inevitable in terms of the life as experienced by the person. A favorite example was provided by the residents in psychiatry at a state hospital who endured a seminar with me which made them uncomfortable because they were told that shock treatment was destructive, psychosurgery was destructive, and medication was of limited benefit. They were encouraged to talk to their patients. That was not what the rest of their supervisors told them. The residents, in reaction, asked me to interview a patient. Most schizophrenics are not dangerous, but the residents chose someone with a history of repeatedly assaulting strange men, who himself was big, muscular, and moved very fast. I insisted that the residents sit in the same room during the interview, knowing that they had never been that close to anybody who moved that fast or was that dangerous.

The patient was grossly incoherent and, when he became coherent, he stuttered very badly. All the residents could have done to choose a more difficult psychotherapy prospect would have been to choose someone who did not speak English at all. The patient had been hospitalized for ten years, but there was nothing in the case records which would account for his disorder. The only apparent major stresses were that he was poor, his father was an alcoholic, he had developed a speech disorder (stutter) as an adolescent which did not respond to speech therapy, and he had reported to sick call in the Army with a venereal disease, whose site was his mouth, just before his first assault on a stranger.

In my value system, which most patients share, one deals first with homicidal danger; second, suicidal danger; and third, anything else. This patient would creep up behind other patients and choke them. The attendants would see feet waving in the air. The patient had not killed anyone (he dropped the victim when the victim was unconscious), but the attendants were worried that he might. Therefore, I kept bringing up this symptom during the first session. Finally, the patient and I worked out what seemed to be going on—that when the patient was a little boy, his mother, for minor offenses like not eating, would put a cloth around his neck and choke him. After that first session he stopped choking other patients. (It is a useful clinical rule of thumb that when you get a dramatic improvement in a symptom, you are probably doing the right thing.) Now this is not the kind of difficulty with which even people with difficult mothers have had to cope.

A second fact came to light in a transference reaction. The patient began a therapy hour by yelling, "Why did you do it to me, Dad?" It is not difficult to recognize a transference reaction when a schizophrenic patient calls the therapist "daddy" or "mommy."

"What did I do?"

"You know what you did!"

When asked how old he was, he said, "You know I was eight years old." Bit by bit he revealed that I had come home drunk and anally raped him. This was not an ordinary alcoholic father. The patient's terrible stutter was also revealed to have an extraordinary cause. In the middle of his stutter there were words in Latin. When asked if he had been an altar boy, he said, "You swallow a snake, and then you stutter. You mustn't let anyone know." He was extremely ashamed and guilty. Apparently, he had performed fellatio on a priest.

He was reassured that it was all right, and it was interpreted orally: "Anyone as hungry as you were would have done the same thing." (With schizophrenic patients much of what seems sexual really has to do with orality, that is, infantile feelings, survival, and the early mother-child relationship. A penis, for example, may represent a mother's breast, and the breast represent love.) At that point the stuttering stopped. When he started to stutter in later sessions, it was only necessary to repeat the interpretation, and the stuttering immediately ceased.

But look at this poor man's life. He turned to mother, and mother was terrible. If mother is terrible, one ordinarily turns to father, but his father was terrible. He turned to God, and the priest was destructive. Would not that drive anyone insane? Yet examination of ten years of ordinary hospital records revealed no basis for his psychosis.

Parents are often concerned that they will be blamed for their child's disorder. Of course, some parents have been obviously hurtful or neglectful. But most parents of schizophrenics are not consciously destructive people. They are often admirable people who will go to great lengths to attempt to get help for their children. While there are always destructive life experiences in the etiology of schizophrenia, sometimes these experiences have nothing at all to do with the parents. Nonetheless, parents of admirable character and with the very best of intentions may harm their children because of bad professional advice, such as not telling a mother how to reestablish the bond with her infant who had undergone surgery. In still other instances, parents repeat with their own child the bad parenting they endured from their own parents (see, for example, Fraiberg, 1977).

Frequently, bad parenting is the result of unconscious defenses which like all unconscious defenses are uncontrollable until brought into awareness, and consequently not an issue of good or bad, but simply a problem to be solved. Although it is fashionable today to deride Fromm-Reichmann's concept of the "schizophrenogenic mother," it is demonstrable if you take the unconscious seriously. In particular, there is a series of careful empirical studies demonstrating an unconscious de-

fense, termed "Pathogenesies," measurable from the Thematic Apperception Test (TAT), to be more common in parents of schizophrenics (Karon and Widener, 1994; Meyer and Karon, 1967). This is not conscious malevolence, and it is not revealed by questionnaires. It has to do with the degree to which, without awareness, one does or does not take into account the conflicting needs of someone who is dependent on you when their needs and yours conflict.

Families with disturbed children also have a tendency to discourage the use of people outside the family as sources of information and corrective identification (Lidz, 1973; Searles, 1965). Patients from very disturbing families who do not become schizophrenic are inevitably found to have remedied the defects in their nuclear families with relationships outside that family. This is the normal mechanism. Nobody ever had a perfect mother or father. Most children, as well as adults, use people outside the family to correct any problems in their family. When parents interfere with this mechanism, any problem in the family is enormously magnified in its destructive impact. Parents do not do this to be hurtful; they are unaware that it has any harmful consequences. Indeed, they may even believe that it is good for the child.

Parents who discourage extra-familial identifications are spared the normal discomfort of having their values and beliefs challenged by their children. But these challenges, whether or not communicated overtly, partially shield the child from being hurt by the mistakes we inevitably make as parents. Usually, there are a succession of small causes which change the conscious and unconscious fantasies which give meaning to subsequent experiences. The psychotic symptoms are always a reasonable reaction to the events of the patient's life, as subjectively experienced, not necessarily as evaluated by an outside observer.

In the 1940s a boy from a wealthy family was sent to various institutions for disturbed children. As an adolescent, he returned home and was seen on an outpatient basis by a psychoanalyst with a well-deserved reputation for incompetence. The boy told his therapist about a homosexual experience. The therapist informed the adolescent's parents. They said to the patient, "Let's go for a ride," and took him for a ride in the family car, a black Cadillac limousine. The patient sat in the back and his parents sat in the front. They said, "We are going to have to get rid of him." When he came back from that ride, he was catatonic. In terms of the imagery of the gangster movies of that era, "being taken for a ride" meant being killed, and the gangster murder cars were black limousines. The patient felt he was going to be killed. Of course, the parents consciously only meant sending him away from home to a residential treatment center to spare the family embarrassment.

## TECHNICAL ISSUES

With schizophrenics, the treatment of choice is psychotherapy with a competent therapist who has relevant experience or training. If the patient, the therapist, and the setting can tolerate it the psychotherapy is best conducted without medication. If the patient asks for it, or the therapist is uncomfortable talking with disorganized patients, or the setting requires it, medication can be used, but it should be withdrawn as rapidly as the patient can tolerate. Medication as an adjunct makes behavioral control easier to attain but slows down the rate of underlying change. This is because medications damp affective responses, which is helpful to the patient. But affective responses during the therapy session are also a part of the process of change.

The therapist must help the patient create a livable world. As in any therapy, forming a therapeutic alliance is essential; but with psychotic patients it is more difficult and forms a more persistent part of the therapist's work. The severity of the symptoms generally means that there have been more bad things to transfer, and hence the transference to the therapist will tend to be negative. When there is ambiguity (or sometimes even when there is not), the therapist may be perceived as hostile, dangerous, shaming, belittling, and/or conspiring against the patient. This makes the therapeutic alliance harder to create and maintain. The therapist should try to be unambiguously helpful; the blank screen will inevitably become a monster. Frequently the patients do not communicate even what they already understand because they do not trust you. It is important to tolerate not understanding; the moment you decide you will not abandon the patient just because you do not understand or the material is painful or the patient is hostile, you are already being helpful.

As in any therapy, what changes the patient is the internalization of the therapist as well as the insights gained. The patient internalizes the therapist into the superego so that the patient treats him or herself in the kindly rational way the therapist would instead of the rigid punitive way that most patients treat themselves (based on their early identifications). The patient internalizes the therapist into the ego as a model for how a human being might be, discarding those quirks of the therapist which are not useful. The patient internalizes the therapy relationship as a model of what a human relationship might be. The process of internalization is central to effective therapy, particularly with psychotic patients, but it goes on without explicit attention as an automatic part of the patient-therapist interaction.

The therapist must repeatedly distinguish between thoughts and feelings versus actions. All thoughts and feelings are permissible; and ac-

tions can best be controlled if the patient dares to allow him or herself freedom of feeling and of thought.

The role of insight is the same as in any psychoanalytic therapy: making the unconscious conscious, changing the defenses in part by awareness, making the connection between the past and the present. Understanding the transference is central. The more severely disturbed the patient, the more obvious the transference reactions. Schizophrenics are constantly trying to solve their problems, but they are too frightened to deal with the real problems directly; they deal with symbols. Only when the symbolic act (or symptom) and the original traumatic experience are reconnected in consciousness can the person overcome it.

### CATATONIC STUPOR

Let us consider the most bizarre symptoms of schizophrenia. Take the catatonic stupor, in which the patients sit in the corner and do not move; and they are either absolutely rigid, or they may be waxy flexible. They may stay in one position for hours or for days. Frieda Fromm-Reichmann (1950) reported that catatonic patients see and hear everything that is going on around them, even though they do not react. They look like they are in a stupor but they are not: They feel as if they will die if they move. Fromm-Reichmann understood this because her patients told her when they finally came out of the stupor.

A number of physiological theories have been postulated, most of which have been demonstrated to be false. But Ratner (Ratner, Karon, VandenBos, and Denny, 1981) investigated animals in a state that used to be called animal hypnosis. If one turns an animal upside down and presses it, it becomes rigid or waxy flexible. Rabbits, lions, tigers, alligators, 70 species of birds, fish, octopuses, in fact, just about every species of animal, fish, bird, and insect tested, show this response. The animals will not move, even if great pain is inflicted. After the passage of time the animals come into rapid violent motion unpredictably, which is like human catatonic excitement.

Classical conditioning experiments, pairing two stimuli while the animals are rigid, lead to learning that can be demonstrated after the animals come out of the rigid state, indicating they are conscious of external stimuli. In fact, this state is identical with the catatonic stupor. Ratner discovered its meaning. Most animals are prey for some predator. Every species has a species-specific sequence of behaviors when it is under attack by a predator—sham death, cries of distress to warn the others in the group, and so on. The last stage seems to be this state of

rigidity. Most predators, if they are not hungry, will kill their prey and save it for later. Some predators will not even attack something that does not move, but most predators will. When the animal goes into this catatonic-like state, most predators act as if they think it is dead. In an experiment with ferrets and frogs, for example, a ferret ate the eye out of one frog in this state and the frog did not flinch. The ferret crunched up the foreleg of another in its teeth, and it did not flinch either. In this experiment with ferrets and frogs, 70% of the frogs survived. According to Ratner, if even 30% survive to one mating, the effect on evolution is massive.

So the catatonic stupor is a life- and species-preservative strategy that is built into just about all living animals, including human beings. The biological evidence is consistent with the clinical evidence from Fromm-Reichmann.

## HALLUCINATIONS

Schizophrenic patients as well as professionals like to say that nobody understands hallucinations. But hallucinations are entirely understandable by Freud's (1900, 1917, 1933) theories of dreams, with a few additions. Today, the concept of the collective unconscious seems scientifically untenable; it was based on the then-accepted biological theory of the inheritance of acquired characteristics, no longer acceptable to biologists. There is no evidence of universal symbols; there are only symbols which are used frequently with a given meaning. But there are always people who will use any symbol with an entirely different meaning.

Unlike most people, schizophrenics hallucinate while they are wide awake. Everyone hallucinates when asleep. Dreams may take any sensory modality but the predominant experience is visual. Schizophrenics also may hallucinate in any sensory modality but the predominant modality is auditory. Whatever other hallucinations they have, they almost always hear voices. This is different from toxic psychoses in which the hallucinations are primarily visual.

Why predominantly auditory hallucinations? Because basically schizophrenia is an interpersonal disorder. If someone is blind, they are more physically incapacitated than someone who is deaf, but in terms of the probability of emotional disorders, deafness is more likely to cause emotional problems because it tends to cut an individual off from other people (Corbin and Eastwood, 1986; Gelder, Gath, and Mayou, 1989, pp. 457-458; Thomas, 1981). But is the capacity to hallucinate while wide awake restricted to schizophrenics? Not at all. It is well known that

starving people start seeing food. It is a human capacity if the motivation is strong enough; luckily, most of us will never be desperate enough to have to hallucinate. A trivial example illustrates the meaning of hallucinations. In the middle of a therapy session, a patient asked, "What's that bell?"

"I didn't hear a bell."

"Well, I did."

"It may well be. There are a lot of funny noises in this building. I work here all the time and maybe, like a lighthouse keeper, I just don't pay attention to them anymore. What did the bell sound like?"

"It sounded like a telephone bell, only very loud."

"That's surprising. A telephone bell I would have heard. What comes to mind when you think of a telephone bell?"

"Trying to get through to somebody."

"I think I know what's happening. I've been talking about what I thought was important, but you know I'm off somewhere; and you wish I would get through to you and talk about what is really going on here."

And then the patient smiled. She was too intimidated to tell the therapist he did not understand and ask why he was talking about irrelevancies when there were some things that were important. The most she could do was wish that somehow he would get through to her; and even that was too frightening to deal with consciously, so she had to have it come through in disguise, as an hallucination.

It is a mistake not to use hallucinations as part of the treatment, just as it is a mistake not to use dreams. Here I disagree with Fromm-Reichmann, who thought that the unconscious was conscious in schizophrenics. Many things which are unconscious in neurotics are conscious in schizophrenics, but there are still many things which are unconscious, and many things, like oedipal material, which may be deep for a neurotic may be a disguised representation of other problems for a schizophrenic.

## DELUSIONS

There are four major bases for delusions. The most important source of delusions is transference (Freud, 1912): reliving feelings, fantasies, and experiences from the past with no awareness that it is the past.

Freud originally thought of transference as a phenomenon occurring only in psychoanalysis, as the chief resistance, which by understanding he was able to transform into its most potent therapeutic tool. Ferenczi (1909/1950) first pointed out, and Freud accepted, that transference, like other resistances, was a defense used to cope in ordinary life. What was unique about

transference in therapy was not its occurrence, but that it was studied. But schizophrenics, if listened to, are not subtle in their transferences.

A young woman alarmed the hospital staff by repeatedly cutting and burning herself. When asked about her religion, she said, "I was raised a Catholic."

"Oh, you were raised a Catholic, but you're not now."

"Actually, I'm a Satanist."

"Why don't you tell me about it."

"I used to feel I had to save people. I had to save all the people in Beirut."

"That's a marvelous image. Beirut, that's a marvelous image. You know who the people in Beirut are, don't you?"

She started to say yes and then she said, "Well, no."

"What's Beirut? Beirut is a city where people kill each other, and then they declare peace. But when you look, they are still killing each other. Then they find out why they are killing each other, and try to deal with those problems and solve them; but they go on killing each other. Then they have a truce, but still go on killing each other. What a marvelous image—your family must have been like that."

She became very interested at that point. "Satan says that if I hurt myself, he'll keep me with him. That's what he says."

She was very scared. She described Satan's voice and his appearance. She described his face in considerable detail. When asked whether she knew anybody who looked like that, she thought and said, "Yes; he doesn't look like it now, but he used to."

"Who?"

"My father."

Indeed, according to later information from the family, her father used to beat her mother, and her mother eventually left the house. One can understand a little girl's belief that pain is the price of not being abandoned.

That hallucination disappeared. All one had to do was to ask the patient to describe her experience, and ask what it could possibly mean.

The second source of delusions was described by Freud (1911) on the basis of insights derived from his reading of Schreber's (1903/1955) book. As is widely cited, Freud derived many paranoid delusions from the fear of homosexuality, viewing them as different ways of contradicting the implicit guilt-producing feeling (for a man), "I love him." Thus, (a) I do not love him, I love me—megalomania; (b) I do not love him, I love her—erotomania; (c) I do not love him (using projection), she loves him—delusional jealousy; (d) I do not love him (using projection), he loves me—the delusional threat of being endangered by homosexuals; (e) I do not love him (using reaction formation), I hate

him—irrational hatred; or, most common, (f) I do not love him (using reaction formation), I hate him, but I cannot hate him for no reason, so (using projection) he hates me, which is why I hate him, and if I hate him, obviously I do not love him—delusional feelings of persecution.

However, secondary sources almost never mention the part of Freud's insight that is most meaningful and essential for therapeutic effectiveness. In the language of libido theory, Freud (1911, p. 70) said that the patient with schizophrenia feels withdrawn from emotional relatedness to everybody. Consequently, he wants to be able to relate to someone again. In addition to the hunger for approval from the same sex parent, people of the same sex are more like us than are those of the opposite sex, and, in growing up, as Sullivan (1953) pointed out, it is usual to feel comfortable in relating closely to peers of the same sex before becoming comfortable with the opposite sex. When one feels withdrawn from everybody, there is a strong urge to get close to people of the same sex. Unfortunately, the patient fearfully interprets this self-curative tendency as "homosexuality."

But is the schizophrenic different from the normal adolescent who is having trouble with the opposite sex? Time spent with friends of the same sex leads to becoming more comfortable both with them and with the opposite sex. This is the normal developmental sequence. With normals and neurotics, too, the fear of homosexuality can lead to withdrawing from friends of the same sex, and that makes relating to the other sex even more difficult. It is useful advice for any adolescent (or adult) having trouble with the opposite sex to spend more time with same sex friends, instead of withdrawing from them. Even the specific dynamics of paranoid feelings as defenses are mirrored in the dynamics of some similar feelings in people who are not schizophrenics.

It is usually helpful to let schizophrenic patients with symptoms based on the fear of homosexuality know that their fear of being homosexual is unfounded (if, as is usually the case, it is unfounded), that they are simply lonely, that their loneliness is normal, and that we all need friends of both sexes. Unless they have had a meaningful and benign homosexual relationship, schizophrenics are not helped by reassurances concerning the increased acceptability of homosexuality, but they always feel understood when their therapist talks of loneliness.

Of course, Freud's views on paranoid delusions have been criticized, fairly and unfairly. The fair criticism is that they account for only some delusions, not all. The unfair criticism is that persecutors in the delusions of women are usually men. But the first to point out this apparent contradiction was Freud (1915) who noted that when a woman is first psychotic, the persecutor is female, and is changed to a male persecutor as a later

development of the delusion, illustrating the general human condition that feelings about men are not necessarily based on experiences with men, nor are feelings about women necessarily based on experiences with women.

The third basis for delusions is that some families actually teach strange ideas. The study of schizophrenic patients (Lidz, 1973) reveals how human beings depend on their families to teach them the categories of thought and the meaning of those categories. Children (and adults) assume that other people use concepts in the same way that they and their family do, unless confronted with understandable contradictions. For example, if a person believes that "I love you" includes in its meaning "I hurt you, physically assault you, occasionally even try to kill you," that person is unlikely ever to be able to relate closely to another in a loving relationship.

The last basis for delusions is the general human need for a more or less systematic explanation of our world and our self. Most people share similar systematic understandings. One who believes the world is flat is normal if the year is 1400, and is suspect if the year is 2001. The belief is the same; it is the relationship to others' beliefs that makes it normal or suspect.

Schizophrenic people have had strange experiences. In part, their symptoms are strange experiences. In addition, their lives often include unusual real events. Therefore, their systematic explanations of their world seem strange. But they demonstrate a need to be as realistic as their anxieties permit. Insofar as discrepancies between their understanding and reality become apparent to them, and as dynamic balances change, the patients continually revise their understanding.

The more intelligent patients are more apt to develop a systematic understanding that is adequate enough to obviate the need for more deteriorated symptoms and, hence, to be diagnosed as paranoid or paranoid schizophrenic. The less intelligent are less likely to develop as functionally adequate a "paranoid system." Because the paranoid system is not an abnormal process, but a normal process used to cope with unusual problems, it is possible for a nonfrightened, nonhumiliating therapist to share the patient's systematic understanding, to respectfully call attention to inconsistencies, and to helpfully supplement the patient's understanding with the therapist's knowledge of the world, of other people and, more importantly, of the workings of the human mind.

## AN "INCURABLE" SCHIZOPHRENIC

A patient termed an incurable schizophrenic by his outpatient psychiatrist who had treated him with medication and psychotherapy, and

by a consensus of the inpatient psychiatric staff who had treated him with increased and combined medications, was brought to my office after his wife, on my advice, refused to permit electro-convulsive therapy and had withdrawn him from the hospital, despite the staff's objections. The psychiatric staff told her she was killing him. He was not eating, he was not sleeping, and he was continuously hallucinating. He was from a middle-class family and had considered himself lucky to have such good parents. However, even before his first psychotic break, he could not remember his childhood before the second year of high school; he did not think this was abnormal.

I immediately stopped all medications and started real treatment—seven days the first week, six the second, and so on, until a regular three-day-a-week schedule. His wife and friends of the family took turns being with him for the first two months. Since not eating can kill you in thirty days, the treatment started with that symptom. The second session was at 7:00 A.M. at an all night restaurant. He said, "I can't go in there. They'll think I'm crazy."

"No," I responded, "They'll think you're drunk."

"I'll throw up."

"Do you think you're the first drunk who threw up here tonight?"

I discussed food, the fear of poisoning, and its possible origins while I ate. The patient reported nausea while watching me eat. By the third restaurant session, he took some coffee for himself. Then coffee and toast at the next session. Finally, he ate breakfast, but he objected: "I'm paying for therapy and all I do is watch you eat. I've got a right to be listened to." At that point we returned to the office for more traditional treatment. Six months later he was working at an intellectually demanding job. A year later I could say to him: "Anyone can go crazy under enough stress, but under the stresses of ordinary life, you will never be psychotic again." He said, "This is better than I have ever been, better than what I used to call normality, but if you think this is good enough for me, you're crazy."

The treatment process eventually became more traditional. We moved to a couch and I sat behind him when it seemed more useful. This patient saw me for 14 years. He kept raising new issues. In his third year, he startled me by saying "I have a book to write and I can't. Is that something that you can help me with?" Somewhat dubiously, I said, "People do go into analysis for writer's block." We spent most of a year on it, and he wrote that book. He has written several since. Others in his field have told me that his professional reputation is based on that first book now considered a classic in his field. Obviously it was well worth a year's analytic work. He knew that, even if I did not.

In his pre-psychotic period, he had never eaten a meal without nausea. During treatment, after a trip to France, he recounted with tears in his eyes, "I can't tell you what French cooking is like. There is nothing like it in the United States."

He went through psychosomatic problems and then marital problems. "I could leave her. There are bright, attractive, interesting women out there, but it would devastate her. When I needed her, she saved my life. The doctors said, 'Shock him.' My family said, 'Shock him.' People in your department said, 'Shock him,' but she had the courage to defy them and see that I got real treatment. And I just can't do that to her."

He described his need for the last two years of treatment: "I have a teenage son. When he was a kid, he had a psychotic father. That was a hell of a thing to do to a kid. And I need help in undoing the harm I did him." The patient is now internationally renowned in his field. He is an outstanding scholar and teacher, as well as a good husband and father. His therapy did not make him a bright man nor a kind man, but it did keep his brightness and kindness from being destroyed. It did allow him to feel safe, perceive and think realistically and creatively, and use his intelligence and kindness to make his own and other people's lives more interesting. That we do not offer such real help routinely to schizophrenic persons is a tragedy.

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