Journal of Contemporary Psychotherapy, Vol. 31, No. 1, 2001

The Fear of Understanding Schizophrenia and Iatrogenic Myths

Bertram P. Karon

Empirically, psychotherapy with a competent therapist is the optimal, but rarely offered treatment, for schizophrenia. Medication or ECT produces less disturbing, lifelong cripples. Within 25 years one-third spontaneously recover completely (unless they stay on medication), and another third socially recover. Nazi Germany sterilized and annihilated patients without decreasing mental disorders in the next generation. Schizophrenia is a terror syndrome. The therapist must create a therapeutic alliance by creating hope and tolerating not understanding. Hallucinations are waking dreams. Delusions are transferences, defenses against pseudohomosexuality, family-specific meanings, or attempts to make sense out of strange experiences.

KEY WORDS: schizophrenia; psychotherapy; medication; genetics.

Psychotherapy with a competent psychotherapist is the optimal treatment for schizophrenics and other serious mental disorders, but it is almost never offered. Instead patients are given medication or even ECT with the effect of making them less troubling but lifelong cripples.

Research like the Michigan State Project (Karon & Vandenbos, 1981) with Detroit inner city chronic schizophrenics showing that even 70 sessions of psychotherapy was more helpful than medication, Benedetti and Furlan (1987) with severe schizophrenics treated intensively with psychoanalytic therapy by private practitioners in Italy with very good results in 80% of the cases, and Alanen (1997) with community mental health in Finland clearly show the advantage of competent psychotherapy that takes seriously the meaning of the symptoms. Research also shows that psychiatrists untrained in psychotherapy cannot do psychotherapy well with difficult patients (Grinspoon, Ewalt, & Shader, 1972; May, 1968). Caring

Address correspondence to Bertram P. Karon, Department of Psychology, Michigan State University, East Lansing, MI 48824-1117; e-mail: karon@msu.edu.

0022-0116/01/0300-0015$19.50/0 © 2001 Human Sciences Press, Inc.

volunteers can be helpful because they know that what they offer is not technical expertise but benign human contact, something which has been missing in the lives of most patients (Mosher & Menn, 1976; Matthews, Roper, Mosher & Menn, 1979). Psychoeducational approaches, which could be of value, usually incorporate false information, which does more harm than good.

The field has been misled by bad research, and by marketing presented as continuing education, which claimed to have demonstrated genetic causes when they did not, biological defects when they had not, cures by medication and shock treatment while the patients did not get better, safety for medications which were not safe, and the myth that patients never spontaneously recover.

Patients are told that their children are doomed, when in fact only 20% of children who are raised by their schizophrenic parent, with genetic and environmental factors working in the same direction, ever become schizophrenic (e.g., M. Bleuler, 1978). And Manfred Bleuler has shown how even this increased risk can be effectively diminished by appropriate preventive counselling or psychotherapy. Patients are told that they must stay on the medication forever and that they have no hope of complete recovery. But all the studies that have followed schizophrenic patients for more than 25 years (Ciompi, 1980; Harding, 1995; Harding, Zubin, & Strauss, 1987) found that approximately one third of the patients will completely recover, that another third will become self-sufficient, and only one-third have the morbid course originally described by Eugen Bleuler and Kraepelin, and still described in most textbooks and in DSM-IV (American Psychiatric Association, 1987). This benign outcome has been true for patients since 1900, so it is not due to any recent medication or treatment. In the best of the American long-term studies (Harding, 1988), fifty percent of the patients stopped taking their medication, usually against medical advice. All of the thirty percent who fully recovered were among that group. No patient who stayed on medication as advised by their doctor ever fully recovered.

Medications do diminish fear and anger and make patients manageable, but they are also neurotoxic (Breggin & Cohen, 1999). At least 40% of the patients who take the older medications continuously will develop tardive dyskinesia in ten years. Some of the newer medications have a decreased risk for tardive dyskinesia, but have other serious side-effects. Nor is tardive dyskinesia the only kind of neurological damage (e.g., Gur et al, 1998); just the most obvious. The recent findings of enlarged ventricles and other abnormalities reflect the medication; as Theodore Lidz pointed out (personal communication, 1990), there were no early MRI and CAT-scans, but there were hundreds of autopsy studies, and these brain changes were not found until the so-called anti-psychotics were in wide use. The study of identical twins, discordant for schizophrenia, which found destructive brain changes in the schizophrenic twin (Suddath, Christison, Torrey, Casanova, and Weinberger, 1990), was cited in the newspapers as having found these differences uncorrelated with medication. That was the conclusion in the article summary, but their data actually show a correlation of .50 with lifetime medication dosage

which reaches the .06 level of statistical significance, and therefore was reported as no correlation, although other findings at the .07 level were reported as real. If the data are corrected for the correlation with medication dosage, there is no difference between the schizophrenic and non-schizophrenic brains.

The Danish adoption studies (Kety, Rosenthal, Wender, & Schulsinger, 1968; Wender, Rosenthal, Kety, Schulsinger, & Welner, 1974; Wender, Rosenthal, Zahn, & Kety, 1971) reported that the rate of schizophrenia in biological relatives of schizophrenics was higher than in adoptive relatives. But in that data the highest rate of schizophrenia was among half-siblings, who were more likely to be schizophrenic than full siblings or than parents. There is no genetic model consistent with that data. The investigators also reported that psychological tests did not differentiate adoptive parents whose adoptive child became schizophrenic from those whose adoptive child was normal, even though they had sent Margaret Singer the Rorschach tests and knew that she had picked out blindly with no false positives and no false negatives those whose adoptive children had become schizophrenic from those whose adoptive child was normal (Wynne, Singer, & Toohey, 1976), using the same criteria from her previous studies that differentiated biological parents who raised schizophrenic children from those who had raised normal children.

But the definitive genetic study has been carried out. The Nazi psychiatrists sterilized all mental patients in Germany for several years, and then designed the annihilation chambers, originally not for Jews or political prisoners, but for mental patients who were the first to be annihilated (Binder, 1938; Breggin & Breggin, 1994; Proctor, 1988). But a generation later, the rate of schizophrenia and other psychoses was not affected (e.g., Haefner & an der Heiden, 1997).

Schizophrenia is a syndrome of chronic terror and defenses against terror, to which any human is subject if life is bad enough. Human beings are not intended to have to live with chronic intense terror. In every case this terror has meaning. I have never known a schizophrenic whose life, as subjectively experienced, would not have driven me crazy. At the time of a psychotic break, there is always an acute conscious fear of dying.

The patients do not communicate very well, in part because of symptoms, but also because they are afraid that what they say may be used against them. They do not understand what is going on, and they do not dare to communicate what they do understand. You must be able to tolerate not understanding, and deal with what you can understand. If you have a particularly difficult patient, I recommend Garry Prouty's (1976) paper on how to get the most regressed uncooperative patient communicating.

The moment you make a decision not to run screaming from the room, you are doing good psychotherapy, even if you have no idea what is going on. It is your job to create a therapeutic alliance by getting across to the patient that you are there to help them, that they have a helpable condition, and that it is only going to take hard work. You must create hope. This is exactly the opposite of what most mental health professionals do with schizophrenics.

It is useful to tell a schizophrenic that you will not let anyone kill them. A simple question, "What seems to be the trouble, how can I help you?" will usually get an answer, which should be treated seriously. The therapist must tolerate, even more than with most patients, not understanding what is going on. If you understand anything correctly and helpfully, the patient will be impressed—that is more than any of the other professionals have done. They then may trust you with more.

Catatonic stupor is an evolutionary response in almost all animals to the fear of impending death, which is effective in reducing fatal attacks by predators (Ratner, Karon, VandenBos, & Denny, 1981).

Hallucinations are waking dreams. Schizophrenics may hallucinate in any sensory modality, but they almost always hear voices, because schizophrenia is an interpersonal disorder. Hallucinations can be readily understood in terms of the psychoanalytic theory of dreams, except that the motivation must be much stronger to dream while you are awake.

The most important source of paranoid delusions, and therefore your first guess, is transference to the world at large of events, feelings, and fantasies from childhood. The second source is the defense against pseudohomosexual feelings, as described by Freud (1911). The patient who feels withdrawn from everyone is attracted to someone of the same sex because we were all comfortable with peers of the same sex before we became comfortable with the opposite sex. At some level the patient unfortunately interprets this attraction as homosexuality, and defends unconsciously (for a man) by "I don't love him, I love me" (megalomania); "I don't love him, I love her" (erotomania); "I don't love him, she loves him" (delusional jealousy); "I don't love him, he loves me" (homophobia); "I don't love him, I hate him" or, projecting the hatred, "He hates me, therefore I hate him, obviously I don't love him." It is usually helpful to get across "You aren't homosexual, but you are lonely, and we all need friends of both sexes." The third source is that families sometimes have special meanings to concepts, which seem delusional when revealed outside the family (Lidz, 1973). If you believe "I love you" means "I hit you and from time to time try to kill you" it is unlikely that you will ever have a close good relation with anyone. The last source is that all of us try to makes sense out of our world and our lives. With unusual life experiences as well as unusual symptoms, the patients do their best to make sense out of their lives. That is why a non-frightened non-humiliating therapist can helpfully offer alternative meanings which will be accepted when they work better or make more sense to the patient than the delusions.

Whether the therapist is active or passive, or of a particular theoretical school is not critical: the therapist must be strong in the sense of willing to think about anything, capable of tolerating not knowing and of making mistakes. Any good paranoid will find your weak spot and make you act in a way that is inappropriate by your own standards. It is critical that you not give up at this point, but simply ask yourself "How did this happen?" and learn from it. You will feel helpless,

depressed, bored, anxious, or angry and always it will be an interaction of the patient's feelings and what the patient is doing to you with your own past. If you pay attention, you will learn.

Transference has three functions. The first is information: the patient re-experiences the past that they cannot directly remember. Secondly, the positive transference keeps the patient in therapy despite its discomfort; with psychotics you have to be more helpful and benign, because their past has been worse. The blank screen inevitably becomes a monster. The third function is "reverse" transference—the patient internalizes the therapist as a more rational conscience replacing the parents; as a model for the self; and as a model of what a relationship with another human being might be.

Many years ago, a patient was treated with medication unsuccessfully, was hospitalized, declared a hopeless schizophrenic by consensus of the hospital staff, and his wife was told that his only hope was ECT, which probably would not cure him, but it was the only hope he had. On my advice, his wife refused to permit ECT and took him out of the hospital despite threats by the medical staff that she was killing him. He could not eat, he could not sleep, and he was continuously hallucinating. I took him off medication, treated him intensively by psychoanalytic therapy, and six months later he was working full time. He stayed in psychoanalysis for years because he kept raising his goals for his personal and professional life. "You have helped me with this and with this. Now is this something you can help me with?" And it usually was.

He is now internationally renowned, as well as having a successful marriage and being a good father. He sent me a magazine article about a prestigious award and a note, "Somehow, it's a shame that my deepest feelings of gratitude for returning a life to me have gone unexpressed."

Remembering that his parents' lack of appreciation was traumatic, I wrote: "Congratulations. It is good to have your work recognized appropriately. From time to time I have heard from people in your field about your accomplishments, and it has always been a source of satisfaction that I was available when you needed me."

But, of course, we feel that way about almost all our patients.

REFERENCES

Alanen, Y. O. (1997). *Schizophrenia: Its origins and need adapted treatment.* London: Karnac Books.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Benedetti, G., & Furlan, P. M. (1987). Individual psychoanalytic psychotherapy of schizophrenia. In G. Benedetti, *Psychotherapy of schizophrenia* (pp.198–212). New York: New York University Press.

Binder, R. (1938). Germany's population policy. *Eugenical News*, *23–24,* 113–116.

Bleuler, M. (1978). *The schizophrenic disorders: Long term patient and family studies.* New Haven and London: Yale University Press.

Breggin, P. R., & Breggin, G. E. (1994). Condemned by science: The role of psychiatry in the Holocaust. In P. R. Breggin and G. Breggin, *The war against children* (pp. 137–156). New York: St. Martin's Press.

Breggin, P. R. & Cohen, D. (1999). *Your drug may be your problem: How and why to withdraw from psychiatric drugs.* Reading, MA: Perseus Books.

Ciompi, L. (1980) Catamnesic long-term study on the course of life and aging of schizophrenics. *Schizophrenia Bulletin*, *6,* 606–617.

Freud, S. (1911). Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides). In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (vol. 12), 1–84. London, Hogarth Press.

Grinspoon, L. Ewalt, J. R., & Shader, R. I. (1972). *Schizophrenia, pharmacology, and psychotherapy.* Baltimore: Williams and Wilkins.

Gur, R. E., Maany, V., Mozley, D., Swanson, C., Bilker, W., & Gur, R. C. (1998). Subcortical MRI volumes in neuroleptic-naive and treated patients with schizophrenia. *American Journal of Psychiatry*, *155,* 1711–1717.

Haefner, H. & an der Heiden, W. (1997). Are mental disorders increasing over time? *Canadian Journal of Psychiatry*, *42*(2), 139–151.

Harding, C. M. (1988, July). *Chronicity in schizophrenia.* Paper delivered at the International Association for Psychosocial Rehabilitation Services conference, Philadelphia, PA.

Harding, C. M. (1995). The interaction of biopsychosocial factors, time, and course of schizophrenia. In C. L. Shriqui & H. A. Nasrallah (Eds.), *Contemporary issues in the treatment of schizophrenia* (pp. 653–681).

Harding, C. M., Zubin, J., & Strauss. j. S. (1987). Chronicity in schizophrenia: Fact, partial fact, or artifact? *Hospital and community psychiatry*, *38,* 477–486.

Karon, B. P., and VandenBos, G. R. (1981). *Psychotherapy of schizophrenia: The treatment of choice.* Northvale, NJ: Jason Aronson.

Kety, S. S., Rosenthal, D., Wender, P. H., & Schulsinger, F. (1968). The types and prevalence of mental illness in the biological and adoptive families of adopted individuals who have become schizophrenic. In D. Rosenthal & S. S. Kety (Eds.), *The transmission of schizophrenia* (pp. 345–362). Oxford: Pergamon.

Lidz, T, (1973). *The origin and treatment of schizophrenic disorders.* New York: Basic Books.

Matthews, S. M., Roper, M. T., Mosher, L. R., & Menn, A. Z. (1979). A non-neuroleptic treatment for schizophrenia: Analysis of the two-year postdischarge risk of relapse. *Schizophrenia Bulletin*, *5,* 322–333.

May, P. R. A. (1968). *Treatment of schizophrenia: A comparative study of five treatment methods.* New York: Science House.

Mosher, L. R., & Menn, A. Z. (1976). Dinosaur or astronaut? One year follow-up data from the Soteria project. *American Journal of psychiatry*, *133,* 919–920.

Proctor, R. (1988). *Racial hygiene: Medicine under the Nazis.* Cambridge, MA: Harvard University Press.

Prouty, G. F. (1976). Pre-therapy: a method of treating pre-expressive retarded and psychotic patients. *Psychotherapy: Theory, Research, & Practice*, 13, 290–294.

Ratner, S,G,, Karon, B. P., VandenBos, G. R., & Denny, M. R. (1981). The adaptive significance of the catatonic stupor in man and animals from an evolutionary perspective. *Academic Psychology Bulletin*, 3, 273–279.

Suddath, R. L., Christison, G. W., Torrey, E. F., Casanova, M. F., and Weinberger, D. R. (1990). Anatomic abnormalities in the brains of monozygotic twins discordant for schizophrenia. *The New England Journal of Medicine*, *322,* 789–794.

Wender, P. H., Rosenthal, D., Kety, S. S., Schulsinger, F., & Welner, J. (1974). Cross-fostering: A research strategy for clarifying the role of genetic and experiential factors in the etiology of schizophrenia. *Archives of General Psychiatry*, *30,* 121–128.

Wender, P. H., Rosenthal, D., Zahn, T., & Kety, S. S. (1971). The psychiatric adjustment of the adopting parents of schizophrenics. *American Journal of Psychiatry*, *127,* 1013–1018.

Wynne, L. C., Singer, M. T., & Toohey, M. L. (1976). Communication of the adoptive parents of schizophrenics. In J. Jorstad & E. Ugelstad (Eds.) *Schizophrenia 75: Psychotherapy, family studies, research* (pp. 413–450). Oslo, Norway: Universitetsforlaget.