

# **TREATING the ‘UNTREATABLE’ HEALING in the REALMS of MADNESS**

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## **PREFACE**

From the beginning of my psychiatric training more than forty years ago, I have been fascinated by people with delusional and schizophrenic disorders. Having treated quite a number of delusional patients from many different diagnostic categories over the intervening years, I'd like to present a theory and clinical examples of successful psychodynamic treatment of even the most disturbed and psychotic patients.

Since this is a problem that affects not only the schizophrenic or delusional patient, but family and friends as well, I have written this book for the general public as well as interested members of the psychiatric profession, in hopes that more people will realize that there is much that can be done for such seemingly lost and confused people.

Many severely disturbed patients, diagnosed as schizophrenic or delusional, respond to antipsychotic medication, full time or partial hospitalization and reality oriented, supportive psychotherapy. Some of these confused people, however, do not benefit from this supportive, primarily medication and cognitive therapy approach, remaining mired in a chaotic and deteriorating condition that leaves little hope for them or their families; they are considered hopeless and “untreatable”.

Here are some facts about schizophrenia in the United States. The average prevalence rate is 3.4 per 1,000 people. One year prevalence in adults, ages 18 to 54 is estimated to be 1.3%. Each year, 100,000 people are newly diagnosed as schizophrenic. On any given day, 600,000 people are in active treatment for schizophrenia; well over two million people suffer from schizophrenia. Including family and friends, perhaps 10 million people in the U.S. have a personal interest in the treatment of schizophrenia and delusional disorders.

Pharmaceutical companies, too, have an interest in the treatment of schizophrenia and delusional states. Through relentless advertising of antipsychotic medications and funding of groups oriented toward supportive care and antipsychotic medication, even medications with tremendous potential for destructive glucose and lipid metabolism side effects have become the standard of care. When their children become schizophrenic or delusional, devoted families believe they have nowhere to turn but to a primarily drug oriented approach which frequently blunts the symptoms but may do little to change the underlying thought processes and return their child to a more functional and related life.

If antipsychotic medication works, so much the better.

All too often, however, antipsychotic medication merely covers over the disturbed and confused thinking that underlies such severe conditions. Gradually, patients may go through a revolving door of psychiatric hospitalization, drug treatment, day hospitals and halfway houses. Some continue to deteriorate in spite of these efforts and become “untreatable” in the eyes of most mental health practitioners and psychiatrists. The best that is hoped for is an adjustment to reality, not a working through of underlying psychological issues and warded off emotions.

I have found over the last 40 years of psychiatric practice, however, that a number of these allegedly “unresponsive” and “untreatable” severely disturbed patients, diagnosed as suffering from schizophrenia, paranoid delusional disorder and multiple personality disorder, have responded to an in depth exploratory psychodynamic psychotherapy. In a number of cases, antipsychotic medication has been titrated down and stopped, as patients who had been floridly psychotic for decades began to understand the psychological factors leading to their deterioration. With comprehension of the psychological underpinnings of their conditions, delusions and hallucinations have diminished and ceased and they have returned to a life of relationships and function.

Because this type of in-depth work with psychotic people is so rarely done, so frequently questioned, and so rarely written about, I have written TREATING the “UNTREATABLE”, a chronicle of twelve schizophrenic or delusional patients who responded to such a psychodynamic approach, when all else had failed. Some of these patients had been hospitalized and medicated for years; others were in and out of hospitals repeatedly before an attempt was made to help them understand the meaning of hallucinations, delusions and previously incomprehensible mental states.

My goal in writing this book is to demonstrate through these successful clinical examples, that an intensive psychotherapy may aid even the most distressed through the morass of psychosis, where previous hospitalizations, courses of antipsychotic medication and ancillary treatments have been of little help. TREATING the “UNTREATABLE” articulates a rationale for the use of an intensive psychodynamic psychotherapy in such a disturbed population and proves false the current belief that such an in-depth exploratory psychotherapy is of no benefit in such severely disorganized patients.

Delusional people have their own belief systems; for them, consensually validated reality does not apply. They are in a world of their own, certain of the correctness of their perceptions and unresponsive to the supportive ministrations of friends and families. We have all seen them, muttering to themselves and, even worse, responding. They seem beyond the ken of human discourse; there is no there, there.

The torment of the deluded is difficult for any of us to fathom. We brush past the shouting, gesticulating homeless madman on the street. We wonder why she sits quietly talking to herself for hours, oblivious to the day’s events. We try to follow the convoluted thinking of the paranoid, or extend ourselves to listen to his fears and improbable anxieties. We see families giving up on their former loved ones who now seem beyond help and redemption. We see lives shattered by delusions and schizophrenic thought; more probably, we avert our eyes.

Once delusional, people are often beyond the pale for most of us. What they utter appears to be nonsensical. The paranoid terrors and grandiose schemes have little or no realistic basis. The inflated or deflated sense of self bears no relationship to other’s perceptions. If anti-psychotic medication and social rehabilitation fail, as they often do in the most disturbed patients, families, friends and even therapists get frustrated and finally turn away with a sense that we have talked with someone who is uncomprehending and beyond help. To most psychiatrists, such people quickly become “untreatable” if they do not respond to a supportive psychotherapy, anti-psychotic medication, half way houses and day care where cognitive therapy and social skills are practiced. Often, such people fall through the cracks and end up in and out of hospitals, extended care facilities or live homeless on the streets.

We are told from early on in medical school that delusions, once fixed, can not be altered, if the standard treatments fail. Such people appear doomed to a life of deterioration and confusion. They don’t seem to understand how the world works. Trapped in a purgatory of their own misconceptions, for all intents and purposes, they are tortured and lost souls. They join the ranks of the “untreatable”.

From the beginning of my psychiatric training, as a medical student on a psychiatry ward, I wondered about our usual modes of treatment of the most severely disturbed patients. It just didn’t seem right to approach psychotic people from a purely biological perspective. Not only did such a drug oriented approach appear superficial, but it left out the essence of the development of the person involved and his capacity for relatedness. It ran counter to my background in English Literature, where plot and character development were the subject of immense interest and passionate discussion.

I began to ask myself and others questions about what was assumed to be the best care available. I was young and searching. I read everything I could find on schizophrenia, its origins and treatment. I worked on the psychiatric wards at Albert Einstein College of Medicine where there were many stimulating teachers, with perspectives ranging from Freudian to Jungian to existentialist.

I spent the better part of my last year at medical school working with Ronnie Laing in London and lived with psychiatric patients at Villa 21 at Shenley Hospital in nearby Dunstable. I pursued gestalt approaches to psychosis in Berkeley during my internship, and, as military service, spent several years evaluating psychiatric drug efficacy for the National Academy of Sciences in Washington D.C., as well as studying in depth psychodynamic approaches to schizophrenic patients at Chestnut Lodge in neighboring Rockville, Md.

From the beginning of my interest in schizophrenia, I thought it was a treatable disorder, if only we could fathom how the person in front of us had slipped into such a perplexing way of being. Even though many in my field thought such patients were beyond any meaningful help, I thought schizophrenia and delusional disorders were eminently understandable, hence treatable.

I liked talking to people who were so disturbed; I found their leaps of logic, their strange associations and their subtle communications to be compelling. Was it my interest in literature and characterization? Was it the fact that this was the mid sixties, with all of the attendant seeking and spiritual and philosophical ferment and exploration?

My questions to myself and others burgeoned.

“Are such patients really “untreatable”? Or have we, as a profession, failed them by a primarily drug oriented approach? Is it possible that “untreatable” as a concept is an indictment of the mental health profession? Do we need a more creative approach to such confusion and despair?”

“Are they really lost? Are these allegedly “untreatable” people reachable, if we but modify our primarily drug oriented approach? What would happen if we tried to plumb the nature and extent of their hallucinations and delusional beliefs? What might the result be if we, as committed therapists, entered into the realm of madness, into the thinking of the seemingly hopelessly disturbed person in front of us? Could change in delusional beliefs and behavior occur if we got to the bottom of how such thinking began?”

“What happens if we genuinely try to understand the origin of such psychotic beliefs, even with the most disturbed, and attempt to put together an emotional and historical thread that describes how delusional beliefs or schizophrenic thought began? Would such an inquiry diminish isolation via an empathic understanding of the confused person and slowly lead to therapeutic and behavioral change? Is it possible that many, who have been regarded as “untreatable”, can be helped?”

By the time I came to Mount Zion Hospital in San Francisco for my psychiatric residency training, I had some pretty clear ideas that it was possible to psychotherapeutically treat the most disturbed patients. There, in Bob Wallerstein’s psychodynamic psychotherapy training program, oriented toward treating the neuroses, I found that a similar approach could also work with schizophrenia and delusional disorders.

My questions began to be resolved as I put my ideas into practice. Soon, as the following cases demonstrate, I realized that there was most likely no such thing as an “untreatable” patient, only our lack of a creative approach, limited by therapeutic attitude, interest, finances and a stable living situation. I began to believe that the concept of “untreatable” was a defensive retreat by my profession, in the face of difficult and hard to reach patients. I had my preconceptions as to what was possible in the psychodynamic psychotherapy of psychosis and began to put them into practice, with predominantly gratifying results.

I played it by ear. I had learned much in my training and had the over-riding belief that it was possible to treat even the seemingly incomprehensible. I never knew what would come up, but something usually did. I trusted and honed my therapeutic instincts, as I began to see more of other therapists’ treatment failures, other psychiatrists’ “untreatables”. Unsurprisingly, I soon became a psychotherapist of last resort for the most disturbed, for people with schizophrenia or delusional disorders.

Over my more than 35 years of out-patient practice with such seemingly hopeless and “untreatable” people, I have confirmed my preconceptions that even the most chaotic and disturbed schizophrenics could be treated psychotherapeutically. I leave it to the reader to see if the material warrants my assessment.

It is my conviction that a thorough understanding of the origin of the beliefs of the most severely disturbed people via an exploratory intensive out-patient psychodynamic psychotherapy, with judicious and appropriate medication as needed, can lead to gradual intra-psychic change, healing and eventual relinquishing of delusional beliefs and schizophrenic thought. The case studies presented in this book will support such an hypothesis.

First, though, we must understand a little about delusions and schizophrenic thought. We must

peek into the world of those ensnared by their beliefs.