Necrophilic Tendencies in Schizophrenia Treatment: Destroying Our Humanity One Behavioral Plan at a Time

Meredith Lynn Friedson

Abstract: Fromm's necrophilous character is evident in state and governmentally run psychiatric hospitals in the United States. Rigid over-reliance on behavioral interventions can be seen as defensive posturing against the terror of uncertainty when confronted with psychosis. Clinical vignettes with institutionalized schizophrenic adults are presented. A plea is made for clinicians to work from a position of respect and love to fight the dehumanization that can result when a psychoanalytic mindset is abandoned.

Keywords: Erich Fromm, schizophrenia, institutionalization, necrophilous, psychoanalysis, annihilation.

Our »normal« »adjusted« state is too often the abdication of ecstasy, the betrayal of our true potentialities, that many of us are only too successful in acquiring a false self to adapt to false realities.
(R. D. Laing 1959, p. 12)

Introduction

This paper is about Life and Death. It is about the insidious insinuation of necrophilic proclivities into the field of mental health, and a call to all who value their basic humanity—and the humanity of their patients—to the essential fight against this. In order to salvage the remnants of compassion and vitality from the necrotic forces that seek to metastasize them, we must fight to remain alive. In this paper, I will provide an indictment against certain attitudes that have been embraced in modern day institutions, and society in general, that are often exclusive of the psychoanalytic stance. More specifically, I will focus on

this within the context of treating Schizophrenic patients and those with other forms of psychosis in an inpatient setting. I will apply Fromm's concept of the necrophilous character to standardized attempts at treatment to demonstrate the ways in which they are deadening.

In *The Forgotten Language*, Fromm speaks of the problems inherent in the need for certainty, and the absence of wonder. He states:

> »If it is true that the ability to be puzzled is the beginning of wisdom, then this truth is a sad commentary on the wisdom of modern man. […] Everything is supposed to be known—if not to ourselves then to some specialist whose business it is to know what we do not. […] In fact, to be puzzled is embarrassing, a sign of intellectual inferiority.« (Fromm 1951a, p. 3.)

I begin here because wonder is vital for the respectful treatment of all patients, particularly those with psychosis. To understand our patients, we must begin from a position of curiosity and possibility. All our experience and knowledge will be useless if we cling rigidly to a position of certainty, or of needing to control. Attachment to facts, as far as any can be determined, will not bring us nearly as close to true understanding, or wisdom, as allowing for possibilities to develop over the course of each clinical, human encounter.

Dreams, psychosis, language, and meaning

Let us now examine Fromm's wisdom on the universal language of dreams and the symbolic. What he says of our resistance to understanding dreams can also be said of our refusal to try to understand psychotic people. In the following statement, let us replace the word »dreams« with »psychotic person« and this point is made clear. He says, »Rather than be confronted with such an overwhelming proof of the limitations of our understanding, we accuse *the dreams* of not making sense« (Fromm 1951a, p. 9, my emphasis). When thrust into depths beyond their comprehension, many who work with psychotic individuals accuse them of being nonsensical. Psychosis, by definition, does not »make sense« in the same ways non-psychotic communications do. But this does not mean it is devoid of meaning or that it lacks internal logic. It merely requires someone willing to try to decipher it, and for that person to earn the trust of the patient so that s/he may be deemed worthy of being allowed to understand what the patient is saying. When approached in this manner, treatment is an enlivening process, not a deadening one.

Many of the schizophrenic people I have worked with experience a profound schism between their minds, their bodies, and the external world; what has been described as a position of »ontological insecurity« (Laing 1959, Sass 2004), or a »self- or ipseity-disorder« (Sass 2001, p. 253), results in a disembodied existence, which contributes to the dream-like quality of their lives. For example, my patients believe they are not who the government says they are; their families are impostors; the spirits of demons, tyrants, and celebrities have inhabited their bodies and family trees; they can communicate telepathically, and read people's thoughts through their footsteps, facial expressions, and gestures that are coded communications meant specifically for them. Even thoughts occur and are expressed simultaneously and intertwined, with no clear delineation of or regard for the distinctions of separate ideas, events, or subject matter; what we call »word salad« is a series of condensed tendrils of thoughts occurring simultaneously which, if followed, each communicate something significant when combined.

One morning, one such patient approached me jovially in the hallway and asked, »Miss Meredith! Is this real?« Thinking back to a question posed to me by a professor in my undergraduate studies I replied, »I'm not sure. How can we be certain we're not dreaming?« He said, »You mean this could all be a hallucination?« I responded, »Well, we'd both have to be hallucinating because we are having this conversation together.« The interaction ended by way of necessity, but I look back at it with fondness because it is characteristic of our work, in which he and I examined these possibilities collaboratively.

Fromm characterizes the symbolic language of dreams as one »in which inner experiences, feelings and thoughts are expressed as if they were sensory […] events in the outer world« (Fromm 1951a, p. 7); he says it is subject to »a logic in which not time and space are the ruling categories but intensity and association« (ibid.). The same is true of psychosis. In my work, I have found that if anything reigns in psychotic states, it is intensity, affect, and association. The process of analytic reverie, through which the clinician can be free enough to explore a shared psychotic space, involves tapping into our own capacity for psychotic thinking. It means allowing ourselves to play with the boundaries of reality. It involves delving into uncharted territory in the hopes of communing with our patients there. This is a scary prospect when often our patients are terrified of very real and omnipresent persecutory threats of annihilation. We are in fact speaking about a matter of life and death, because psychotic flight from reality and annihilation go hand in hand. Our patients can only psychologically survive if we combat the root of annihilation, which is the impossibility of connection in the first place. When we refuse to attempt to make this connection, to join them in their worlds, we are essentially trying to necrotize

them. It is therefore not a huge leap in logic to say that schizophrenic people, in what may seem psychotic ramblings, are protesting the society that would rather see them locked up and forgotten, thrown into hospitals, prisons, homeless shelters, or the streets, and medicated or sedated into silence, than listen to their truths and treat them with compassion, as fellow human beings with a valid perspective on existence that, while divergent from the accepted group narrative, has its rightful place within human society. None of this accounts for the actual threat of physical and sexual violence that takes place in these settings, or the fact that countless deaths have transpired without acknowledgement. But that is an issue beyond the scope of this paper.

Necrophilic treatment: Destroying our humanity one behavioral plan at a time

My experience has led me to believe that psychiatric institutions of mental health—specifically state and governmentally run hospitals in the United States who endorse the latest »golden standard« of »evidence-based treatment«—serve as prisons run by deathkeepers. With each mandate to approach therapy primarily in terms of measurable goals, concretized interventions, treatment plans, and other attempts of proving that what we do is effective (in meeting our own goals, rather than our patients'), our understanding of complex problems such as schizophrenia, trauma, depression, loss, and the human condition, becomes diluted. Attempts to »objectify« and simplify what our patients present merely reduces their dynamic lived experiences and communications into caricatures that we cannot hear, see, or understand. This dynamic allows treatment providers to impose their own goals, values, and sense of reality on patients in an attempt to eliminate symptoms without taking the time to understand their origins. Those in a position of power then implement their expectation that patients conform to their demands, instead of listening first to what patients are saying they think, feel, and need. This tendency in treatment providers can be seen as an embodiment of what Fromm describes as the necrophilous character, which is reflected in and reinforced by the larger institution (Fromm 1973a).

In an effort to justify psychoanalytic work to administrators who often don't have the training to comprehend it, nor the investment to support it due to conflictual financial motivations, the act of treatment becomes so bastardized that it evolves into a self-congratulatory attempt at murder. This perhaps eases the minds of treatment providers, but does little to aid patients in healing. Mackie (2016) describes this as stemming from »a conceptual vacuum that has

been filled with bureaucratic attempts to define the kind of work that is done with psychotic patients« (p. xxvi).

The result can be seen as enacted sadism, which Fromm describes as »the passion for unrestricted power over another sentient being« (1973a, p. 6). There is no greater example of this than trying to control or change what another person thinks, feels, believes, says, and does, all the while striving to be the sole interpreter of the validity of that person's perceptions and the meaning of their experiences. The argument exists that someone who lacks insight, exhibits poor judgment and dangerous behaviors, and ceases to function in a society that collectively determines what is true, is in need of a dose of reality. However, if sanity can be restored to the point that these individuals are able to rejoin society, it will not be imparted by us, »The Authorities,« unto them, »The Patients.« Furthermore, the goal of rejoining a society that often functions in pathological ways and requires an untenable sacrifice of subjecthood involves a grave assumption that participation in that society is a superior way of engaging in the world, as opposed to a valid refusal or rejection to abide by the insanity that contributes to its toxicity.

Let me be clear: I am not romanticizing psychosis or proposing an absolutist relativism in which all reality is subjective and no truths can be concurred upon by a collective group. Within any society there is sound logic, and thinking that is clearly illogical. Both are not equally true in a societal sense, but both are equally valid in terms of how they influence each person's experience of being alive in the world. Furthermore, I have seen all too frequently a rush to condemn psychotic realities, even when they are benign and do not impair functioning; for example, one patient was convinced that he was a famous basketball player when in fact he was not. The unit psychiatrist kept emphasizing the need to eliminate this delusion, as it signified his ongoing psychosis, and was therefore an impediment to being discharged.

I felt that this delusional belief would not significantly hinder the patient from engaging successfully in the world. The patient's belief must serve some purpose to him that we did not fully understand. Who were we, then, to try to rob him of this aspect of his identity? I am not suggesting that we should avoid trying to alleviate distressing symptoms; if we are able, we should. But unilaterally denying a person's subjective experience, deeming it invalid because it is obviously psychotic, and focusing solely on the symptoms is not the way to successfully achieve this goal. I cannot count the times when various mental health providers tried to »reason« with their schizophrenic patients, in a coercive bid to get them to recognize that their understanding of reality is wrong and that of course, the rest of the world that is telling them they are crazy, is right.

Fear of uncertainty leads to psychological murder-suicide

While mental health providers are ostensibly drawn to the field in part because of a wish to alleviate suffering, and have a professional and ethical mandate to do no harm, the failures in empathy inherent in refusing to understand our patients' plights actually lead to the antithesis of this calling. When used rigidly and defensively, behavioral plans, manualized treatments, and the new fad of objectifying complex therapeutic dynamics as »evidence-based,« are the mechanism through which we destroy our capacity for understanding in favor of pretending to know. All these tactics can be and often are implemented as a phobic reaction to uncertainty. The goal is to ward off the indigestion and discomfort of not knowing how to deal with the chaos and mess of human suffering. And while there is perhaps comfort in a reified world of certainties, this world blinds us to the nuance of human experience and severs our connection with our patients' existential struggles. This is a process of defensive self-preservation, but we are not the ones at risk of being annihilated, at least not by making ourselves open to our patients. This approach fails to benefit our patients and ultimately leads to our own spiritual demise.

I have sat in »treatment planning meetings« countless times and felt the encroaching pressure of being forced to suppress my humanity and clinical instincts in favor of mechanized, robotic, purportedly »objective« measures that, because of their concreteness and limited scope, reduce the idea of treatment to meaningless acts that promote the progress of no one. The relationships I work hard to cultivate with my patients cannot be demonstrated or maintained with neat bullet points in bureaucratic paperwork. They require respect and mutual vulnerability, and with each concretization of our patients' existence, we as treatment providers become further distanced and detached from all that is required for such human connection. As my mind goes numb with the madness of these futile attempts to document »progress«—which is entirely disconnected from the people I am privileged enough to treat—I often find myself wanting to scream, as my patients do, that *these are human beings we are talking about!*

I am here reminded of Charlie Chaplin's inspired speech in *The Great Dictator*, where he says:

> »Soldiers! Don't give yourselves to brutes—men who despise you—enslave you—who regiment your lives—tell you what to do—what to think and what to feel! Who drill you—diet you—treat you like cattle, use you as cannon fodder. Don't give yourselves to these unnatural men—machine men with machine minds and machine hearts! You are

> not machines! You are not cattle! You are men! You have the love of humanity in your hearts! You don't hate! Only the unloved hate—the unloved and the unnatural! Soldiers! Don't fight for slavery! Fight for liberty!« (Chaplin 1940)

The ways in which this speech mirrors psychiatric units is chilling: patients are told when to wake up, shower, shit, and eat. They are told what to eat—and it is usually disgusting, unappetizing slop. They are told when to take their medicine and that they have to take medicine; otherwise they will be held down, restrained by multiple people, and given an injection in their rear, pants down, exposed. They have no actual right to refuse neuroleptic drugs most of the time because the court systems will legally mandate compliance. They are told what bed to sleep in and whom their roommate will be, as well as to not have sex, masturbate most of the time, or touch or hug or request a handshake. They are told what to wear (which often does not fit), where to sit, to stop talking or to talk more or to say different things than what they are presently inclined to say. When they wail loudly in agony they are told to be quiet and go away and when they remove themselves from this madness, they are told they are withdrawn, isolative, and guarded—clearly mentally unwell. People who are merely struggling to survive are treated as subhuman and often take on the fight against being enslaved with a heavy sigh, their spirits beaten down after so many years of being told, »you are irrelevant.«

I could read Chaplin's (1940) speech to my patients and it would resonate, and in reflecting on the sentiment that only the unloved hate, I wonder whether it is the patients or staff members who are seeking love and validation, a cure to the human predicament. Perhaps it is we who hate what they represent; maybe we resent the fear and pain they induce in us when we get any closer than completely detached. We develop machine hearts and machine minds when we allow psychoanalytic treatment to become poisoned by mechanistic attempts to justify what we do—a profound act that, while it does in fact have evidence and can be explained in such a way, is more an art form to me, and when implemented in this way becomes so constricted and suffocating that it and its participants risk death.

Fromm suggests that the way to combat this pull towards deadness is by embracing a more biophilic position (1973a). He says, »Genuine freedom and independence and the end of all forms of exploitative control are the conditions for mobilizing the love of life, which is the only force that can defeat the love for the dead« (1973a, p. 10). If our patients fear they are dying, dead, being poisoned, are under siege, decaying, and atrophying every day they are held in an institution against their will, isn't the logical conclusion to try and restore

their sense of vitality and agency through any means possible... including listening and trying to understand them?

Clinical vignette

There is a man who has spent the majority of his life—over four decades—institutionalized in the hospital. He is extremely intelligent and reflective, sensitive, articulate, funny, and well read. Unfortunately, he is also chronically suicidal, impulsive, and aggressive when he encounters memories of multiple traumas he sustained in his youth. A multitude of things set him off, including sensory overstimulation, as he has Asperger's Syndrome. He consistently has enuresis and occasionally encopresis, which contributes to him waking in a foul mood. He often screams homicidal threats and begs to be put out of his misery through death. His plight is made worse because of his intelligence, his acute awareness of his struggle, and his pronounced hopelessness. I have thought about this man as someone for whom the trauma of being alive is too great to bear, in part because his pain is the result of multiple people throughout his life exerting their necrophilous urges upon him.

As a result, he has taken the next logical step and embraced the Frommian necrophilous character within himself and strives to embody this in his daily life. His original passions having been destroyed, he protects the shell that remains by idolizing tyrants with untempered power, and he reveres those who can annihilate completely. This is a man who wants to one-up Satan, and who feels he embodies the villains from his comic books. Dictators who have exerted their power ruthlessly to enact their destructive urges appeal to him because maybe if he had had their power as a child, he could have saved himself. Perhaps this is my own wishful thinking in an attempt to create rational meaning as an explanation for sociopathic impulses in a man who calls himself a sadomasochist, and who would take pleasure in raping me and »kick(ing) (me) in (my) pussy,« as he is so fond of telling me he would like to do. But Fromm's writings on this topic are useful because this is a man whose life is based upon the exploration of meaning in human existence. He is not one-dimensional and actively struggles with striving to understand his experiences within the context of the society in which he is located. The only means he has is to utilize his mind for this exploration, as he is unable to move beyond the four walls of what has now become his home, and prison. He debates the nature of mankind and god(s) alike, questioning, are they good or evil? Merciful or merciless? As if the answer would reveal something about his core self.

ERICH FROMM STUDY CENTER BERLIN
INTERNATIONAL PSYCHOANALYTIC UNIVERSITY BERLIN
Publication of the Erich Fromm Study Center at International Psychoanalytic University Berlin

KSG supported by Karl Schlecht Stiftung

The necrophilous character of psychiatric institutions

Mackie (2016) describes institutionalization as »the application of inflexible systems of control in the treatment of vulnerable people that lead to the stripping away of whole areas of identity« (p. 9). When patients enter an institutional setting, we rob them of their names, their clothing, their belongings and connections to the world; many are not recognized as individuals who are rooted within a familial lineage, history, and culture. Unfortunately, after decades in an institution, families often cease to be present, reinforcing this idea of namelessness; our patients are no more living, breathing fellow human beings, but inanimate entities to be manipulated according to our whims. Fromm suggests that emotional distance reduces our ability to identify and empathize with others (Fromm 1973a, p. 121). We create this distance by using linguistic distinctions as a means of justifying our cruelty; a person named James, upon being admitted to a psychiatric ward, becomes »The Patient,« with the preceding article added for further emphasis of his objectification. People are reduced to categorical groups of the Other so we don't have to care about the ways we hurt them, or indifferently watch as they suffer. Hospitalization done this way underlies the core of human destructiveness, aggression, and necrophilia of which I speak.

We otherize all the time. Diagnosis and categorization are too often used to dehumanize; when malignant predilections are left unchecked, terms like immigrant, Jew, Black, transgender, and atheist can be wrongly translated to connote ideas like vermin, property, abomination, and immorality. In the field of mental health, »schizophrenic« and »borderline« too often become justifications for dismissal. This is how genocides slip into action. Tutsis become »cockroaches,« Muslims become »terrorists,« and suddenly it becomes fathomable to meet eugenics with silent complicity, as we refuse to acknowledge what we have allowed ourselves to become.

Those unfortunate enough to end up stagnating in state-run psychiatric hospitals become victims of institutional necrophilia; their will, vitality, and autonomy are stifled by a system that deems their subjectivity wrong, pathological, and irrelevant to their own recovery. In addition, as an employee of such a machine, I am required to set aside my clinical judgment, emotional heart, and empathic spirit, in order to adhere to a set of rules and regulations so constricting that in the process of trying to survive such a climate, I find myself thinking that the institution wants me dead, or is trying to kill me. Survival becomes doubtful because it means killing off parts of myself, and this induces in me a parallel experience of the »paranoid« and »delusional« ideation my patients express all the time. R. D. Laing says,

> »It is […] possible to have a thorough knowledge of […] the psychopathology of schizophrenia […] without being able to understand one single schizophrenic. Such data are all ways of *not* understanding him. To look and to listen to a patient and to see ›signs‹ of schizophrenia (as a ›disease‹) and to look and to listen to him simply as a human being are to see and to hear in […] radically different ways.« (Laing 1959, p. 33.)

The reason my heart was broken in the pursuit of my work is because of the institution's necrophilous orientation, which is a direct affront to my biophilic approach to clinical work, relationships, and my love of patients, life, and play (Fromm 1964a). Like Plato's (1943) prisoners in *The Allegory of the Cave*, those of us with biophilic orientations to Life would prefer to be freed from the safety of our shackles and to ascend into the startling—and at first—uncomfortable light. Rather than trust in shadows on the wall because that is what we are told from day one is the truth, we are open to the possibilities and growth—indeed, the aliveness—that comes with exploration of the unknown. Uncertainty is life giving and life affirming, but too often we perceive it as annihilatory.

Let us now return to my patients who believe that some one or some thing is trying to kill them. Banging their heads against a wall in an effort to die becomes the manifestation of this cruel, soul-crushing, necrophilous oppression. I sometimes feel that in this act, they are doing exactly what the system has asked of them. Then we intervene and tell them they are not allowed to harm themselves, and we will strap them down to prevent this expression. One such patient has told me I am his torturer: neither allowing him to kill himself, nor assisting him in the elimination of his painful memories, I am the constant reminder of the demand that his suffering continue interminably. The irony of preserving such an existence and calling it Life is neither lost on him nor me, and being unable to offer any alternative to his prolonged agony, it becomes less and less tenable that there is only one sadist in the room.

Conclusion

Eigen says, »The rage of a psychically dead person can be terrifying« (2004, p. xxiv). Could it be that schizophrenic people are actively grappling with states of existential deadness that treatment providers would rather deny in themselves? That making contact with such a person induces in us similar terror and we are shocked by being confronted with the possibility of also experiencing death? To know death intimately, to carry it in one's psyche and body, and

to continue existing despite this, means that many schizophrenic people are fighting like hell to become alive again. In some respects, the awareness of this plight and concurrent struggle means they possess more vitality, in that they are actively struggling against it. Being so acquainted with deadness means that these individuals can recognize it in others, and it must be maddening to encounter the familiar in those designated to treat them, only to have it disavowed instead of used as a tool for recognition.

I don't have a cure for schizophrenia. There is much I can't control. What I can do is try to be the best human I can be in the presence of these other humans who are suffering. And to deny compassion when they are in this frightening state is cruel—and inhumane. When faced with the terror of what our patients bring with them when they enter the room, we try to cure ourselves and say we are curing them. Only by recognizing this can we begin the honesty of genuine treatment.

References

Chaplin, C., Chaplin, C., Goddard, P., and Fox Video (Firm) (1940): *The Great Dictator*. United States (Charles Chaplin Film Corp.).

Eigen, M. (2004): *Psychic deadness*, London (Karnac Books).

Fromm, E. (1951a): *The Forgotten Language: An Introduction to the Understanding of Dreams, Fairy Tales and Myths*, New York (Barney Rosset).

– (1964a): The Heart of Man. New York (Harper and Co.)

– (1973a): *The Anatomy opf Human Destructiveness*. New York (Holt, Rinehart, & Winston).

Laing, R. D. (1959): *The Divided Self,* London (Tavistock Publications Ltd.).

Mackie, B. S. (2016): *Treating people with psychosis in institutions: A psychoanalytic perspective*, London (Karnac).

Plato (1943): *The Republic*, New York (Books, Inc.).

Sass, L. (2001): »Self and world in schizophrenia: Three classic approaches,« in: *Philosophy, Psychiatry & Psychology*, Vol. 8, pp. 251-270.

– (2004): »Some reflections on the (analytic) philosophical approach to delusion,« in: *Philosophy, Psychiatry & Psychology*, Vol. 11, pp. 71-80.

Dr. Meredith Lynn Friedson, Adelphi University New York, Candidate at the Psychoanalytic Postdoctoral Program at NYU, Assistant Professor in the Department of Psychiatry at Mount Sinai, New York, NY 10001, USA, E-Mail: meredithfriedsonphd@gmail.com

in: Fromm Forum (English Edition – ISSN 1437-1189), 23 / 2019
(Special Edition, ed. by R. Funk and Th. Kühn), Tuebingen (Selbstverlag).