

ON SCHULTE, WERTHEIMER, AND PARANOIA

by Abraham S. Luchins

with

1. an excerpt from "Field Theory and Personality," Chapter 14 in A.S. LUCHINS & E.H. LUCHINS, *Revisiting WERTHEIMERs Seminars*, Vol. II (1978)
 2. an additional contribution by Daniel J. LUCHINS, M.D.:
Some informal comments (in 1996) from a biologically-oriented psychiatrist on SCHULTEs Theory of Paranoia (as presented in ELLIS, 1938) and
 3. an additional remark by A.S. LUCHINS
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WERTHEIMER presented (in about 1936-1937) the case of a wounded delusional Russian Tartar - a prisoner of war - being treated in an Austrian Army hospital. He used the case to illustrate the role of the social field in producing psychopathological behavior. He contrasted the biological organism-centered or ego-centered approaches of KRAEPLIN, FREUD and ADLER with the thesis that the nature of the person's social world has to be understood in order to help him. WERTHEIMER pointed out that there is a need in people to relate to others. The Tartar was unable to do so in the hospital situation which he did not comprehend; he did not understand German and no one there understood the Tartar language. Because of the need to be related, he developed a pseudo- or idiosyncratic conception of his relationship to the others. In WERTHEIMERs terminology, the Tartar became a "we-cripple" due to the social field conditions.

Most of the seminar members, including MASLOW and other psychoanalytically-oriented individuals, generally agreed with what WERTHEIMER was saying, partly because it was stylish to explain behavior in terms of social factors. They did not focus on whether or not the thesis presented was a Gestalt theoretical explanation of paranoid behavior. They focused on the role of the social field in personality structure and function, particularly in psychopathology.

At present, more than before I became a clinician, I regard the SCHULTE-WERTHEIMER thesis as a kind of model rather than as a theory about paranoia. A model may be used to convey information or to describe a phenomenon "without the pretense of being unique, complete, or ultimate" (Robert J. SCIAMANDA, *Quantum*, Nov./Dec. 1996, p.45). A model is as good as the data on which it is based and on adequately reflecting the phenomenon for which it is constructed. The SCHULTE paper presents seminal ideas. It implies a theory of delusions of paranoia but presents meager data or information. What are the conditions under which a patient manifests or does not manifest paranoid behavior - in what places, in what situations, with what activities, and with whom, who, what, where, and when? Similarly a taxonomy is needed of a patient's different we-relations. What are the conditions under which he does or does not form we-relations as well as the conditions under which they are transformed or destroyed? What factors minimize and maximize formation and maintenance of we-relations? How does the larger field in which the we is formed affect its structure and function?

Some answers to such questions can be found through small group research. This is a field where clinicians and social psychologists can join in interdisciplinary research to study group structure and group functioning of patients in and out of the hospital.

Normal people also have hallucinations, delusions, or misperceptions and misconceptions. What are the differences and similarities between their experiences and the corresponding experiences of patients? And how do the ways in which individuals correct themselves compare for normal people and psychotic patients? Preliminary studies were undertaken with normal subjects, based on discussions in WERTHEIMERS seminars (e.g., *WERTHEIMERS Seminars Revisited: Problems of Perception*, Volume V, 1974, pp. 261 ff). Preliminary studies of patients' delusions and hallucinations were made when I worked for the U.S. Army and Veterans Administration. Methods were also developed to help patients correct their delusions and hallucinations. The methods and results are described in papers on group psychotherapy, e.g., the role of the social field in restructuring patients' perceptions. Some of the methods are related to the psychosocial biological approach used by Adolf MEYER (1913) for treating and rehabilitating patients to entertain alternative hypotheses as well as to the methods used by Oskar DIETHELM (1936/1955) to introduce habits of doubt about false interpretations. Perhaps because of the disruption of communications in World War I, MEYERs paper may not have been read by SCHULTE. The methods are also related to Adhemar GELBs and Kurt GOLDSTEINs treatment and rehabilitation of brain-injured soldiers of World War I. It is of interest to compare the methods with those of moral treatment in American asylums in the nineteenth-century.

In a general sense, the methods are similar to those described by WERTHEIMER for productive thinking, problem solving, teaching and learning. They also fit WERTHEIMERS challenge that the duty of the therapist is not merely to diagnose or theorize about the patient but to help him. It is a problem solving situation for both the patient and the therapist who, with social support, create a learning environment. The idea is change the patient's focus and to help him to recenter his concepts of his social relationships, e.g., through role-playing, psychodrama, and action research in his everyday life. The goal is to help the patient restructure his phenomenal world, to develop a viable world that is compatible with social reality. In my personal experiences, it is important to be optimistic about achieving this goal and to convey this optimism to the patient.

Footnotes

(1) Cf. Heinrich SCHULTE (1924). At the time of WERTHEIMERS seminars, the abridged translation ("An Approach to a Gestalt Theory of Paranoia," Selection 31 in Willis D. ELLIS, *A Source Book of Gestalt Psychology*, Harcourt Brace, 1938) had not yet appeared. For a complete translation, see Erwin LEVY, "A Gestalt Theory of Paranoia," *Gestalt Theory*, Vol. 8 (4), 1986, pp. 230-255, who refers to the SCHULTE-WERTHEIMER theory. A.S. LUCHINS & E.H. LUCHINS, *Revisiting WERTHEIMERS Seminars*, Bucknell University Press, Vol. II, 1978. pp. 138-142, presents WERTHEIMERS comments on the case of the Tartar and paranoia.

(2) Cf. A.S. LUCHINS, *A Functional Approach to Training in Clinical Psychology via Study of a Mental Hospital*, C.C. Thomas, 1959.

(3) At times it was difficult to distinguish between delusions and what the psychiatrist Carl WERNICKE in 1906 called "overvalued ideas". Recently Paul R. McHUGH wrote "an overvalued value has three characteristics: (1) it is a self-dominating but not idiosyncratic opinion, given great importance by (2) internal emotional feelings over the significance, and evoking (3) persistent behavior in its service" (*The American Scholar*, Winter 1997, p.20).

(4) Cf. "The Role of the Social Field in Psychotherapy," *Journal of Consulting Psychology*, 1948, Vol. XII, pp. 417-425 and "Restructuring Social Perceptions: A Group Psychotherapy Technique," *Journal of Consulting Psychology*, 1950, Vol. XIV, pp. 446-451. A recent study at the University of Chicago Pritzker School of Medicine found that patients who were not demented could correct some of their misperceptions. The results were similar to ours.

(5) Adolf MEYER, "The Treatment of Paranoid and Paranoid States," in William A. WHITE and Smith E. JELLIFFE, Eds., *The Modern Treatment of Nervous and Mental Diseases*, Volume I, pp. 614-661, Lea & Febiger, Philadelphia, 1913.

Oskar DIETHELM, *Treatment in Psychiatry*, Macmillan, New York, 1936/1955.

(6) Albert DEUTSCH, *The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times*, Doubleday, Doran, Garden City, New York, 1937, Columbia University Press, New York, 1949. Nancy TOMES, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping, 1840-1883*, Cambridge University Press, New York, 1983. A.S. LUCHINS, "Moral Treatment in Asylums and General Hospitals in 19th-Century America," *The Journal of Psychology*, 123(6), 585-607, 1989; "The Cult of Curability and the Doctrine of Perfectibility: Social Context of the Nineteenth-Century American Asylum Movement," *History of Psychiatry*, iii, 203-220, 1992.

(7) For example, Kurt GOLDSTEIN, *The Organism; A Holistic Approach to Biology Derived from Pathological Data in Man*. American Book Co., New York, 1939; Zone Books, New York, 1995.

(8) *Productive Thinking*, Harper, 1945/1959, and "The Syllogism and Productive Thinking," 1925, Selection 23 in ELLIS, 1938.

From "Field Theory and Personality," Chapter 14 in A.S. LUCHINS & E.H. LUCHINS, Revisiting WERTHEIMERs Seminars, Vol. II, 1978, pp. 138-139

WERTHEIMER presented an illustration from psychopathology to show the effects of the social field on a person (cf. SCHULTE, 1924). A wounded Russian Tartar was captured alone and treated in an Austrian Army Hospital where he developed delusions of being persecuted. He also heard voices, showed extreme anxiety and made suicidal attempts. This was diagnosed as an acute paranoid episode. WERTHEIMER asked, What is the cause of such behavior? According to KRAEPLIN, you must study his pedigree, look for paranoid tendencies in his history and look for glandular disturbances. One tries to show that paranoia is due to innate disposition. According to psychoanalysis it has a homosexual basis; therefore, you study the historical development of the libido to find that it is due to unconscious homosexuality. You may find an unresolved Oedipus complex, he loves his father, is not loved by girls, he desires men but finds men cold, he thinks that they hate him, and therefore he gets delusions. In response to a question WERTHEIMER said that according to ADLER an inferiority complex causes paranoia and then asked, What do all these explanations have in common? The situation in which the man finds himself and what happens to him in it are ignored. Someone said that these theorists do look at the situation, they look at it in terms of their theories for the cues that indicate the operation of the factors that are basic in their theories. WERTHEIMER remarked, There is a lack of realization of what actually happens to the particular individual in the present. You get a different picture if you consider that the Tartar was captured alone and was placed in a strange hospital. He was brought into a field of which he is to be a part, a patient; he is a member of a group of people in a room all of whom talk to each other but not to him. In this field there are forces that make him feel that they are against him; he is given medicine and an operation and is forced to cooperate. He does not speak German, no one knew his Tartar language. He knows nothing of occidental hospitals; he cannot understand the field that acts on him but he cannot escape. He is in a hospital of the enemy. What are they trying to do to me, it hurts, I cannot resist, I must do as they tell me. This led to excitement, caused tensions. He wants some sort of relation to the field, he feels in need of communication but cannot get it. He finally relates himself to it as the group versus him. A situation arose in which he wanted to become part of a We but he was a We-cripple. The focus of all his thinking is directed on this particular difficulty. He dashes himself against the obstacle, he is excited, bewildered, panicky. He feels something is wrong; he feels as someone apart from the others, as outside of the group. This feeling creates isolation, a feeling of I versus others; they versus me. His ego becomes

important; it is an ego not related to anyone. WERTHEIMER asked, How does a man in such a situation behave? He might take it as a theater scene, but he hears the others talk and he is excluded. He wants to know what they are talking about; he makes a hypothesis; they are talking about me, against me. Everything now is interpreted in light of this conception of the situation; the disequilibrium is now changed into an equilibrium. They are talking about me, the doctor wants to poison me. The situation is now clarified; things have meaning; he has a relationship to the field and has a mode of conduct in it; he fights to save himself; he tries to escape by suicide.

Someone interrupted to ask what happened to the Tartar. WERTHEIMER said, they got a man who understood the Tartar's dialect; he talked to him and he was cured.... WERTHEIMER remarked that some say that paranoia is never cured.

Other Comments:

Daniel J. LUCHINS, M.D.

Some informal comments (in 1996) from a biologically-oriented psychiatrist on SCHULTEs Theory of Paranoia (as presented in ELLIS, 1938):

1. Let me start by saying that the paper appears to be concentrating on abstraction. People need to feel part of a group (we-ness). When this is interrupted they may develop paranoia (ideas of reference, persecution or grandiose illusions) to reestablish some we-ness. It may be useful to think of such behavior as related to a need to belong to a group -- but that doesn't mean that the "need to belong to a group" exists outside of our use of this as a construct.

2. The theory is not biologically based. It makes no reference to the brain or to evolution. Currently most biological theories of psychopathology will make a reference to at least one of these. For example, you can argue that people develop misidentification syndrome because of damage to systems relating to facial recognition. Bowlby's work on depression as related to maternal deprivation experiments in monkeys and the biological importance of maternal-child bonding might be a second example.

Paranoia may have to do with evolution. Phobias may have an evolutionary basis. The capacity to fear; the fear of falling; agrophobia - no place to hide - evolution has given us the fear of being cut off from the tribe, cut off from comfort; the social fear of strangers - a new face not in your tribe may be a threat. People have a need to be connected in a tribe, a family, a group, a "we."

My own theory of paranoia would lean towards the evolutionary explanation. "If you don't know what's going on, it's safer to think that it involves you than to ignore it." You are walking in a wilderness 6 million years ago - a branch breaks - do you think it might mean that there is a tiger planning to jump on you or do you think, "Could it just be the wind?" It probably is to your advantage to have the first view, the "fall back" position, and turn to the alternative view when you know more about what is going on.

When people don't know or trust what's going on, paranoia may occur. They probably fall back to a more familiar situation. For example, when the computer jams, you may think it means, "O.K.. Watch out. You better watch out. It probably has to do with something you did."

3. There is some support for this view. In experiments with hallucinogenics, students start to show paranoia when they stop knowing what is really going on, i.e., this is an experiment, that is an MD, I'm being paid to do this, etc. The same explanation probably relates to the increased paranoia seen in people who are deaf, new immigrants, after cataract surgery when visual images are interfered with, etc., etc. - all situations in which there is a breakdown in the usual ability to "know what is going on."

4. Obviously, one could say that in all the situations discussed in 3, there is a reduction in "we-ness," but I don't believe that adds anything, and is rather too narrow. There is a breakdown in knowing what's going on. For example, I was walking past a parked car one day and the windshield wipers moved. I thought "Did I bang something, is there a light beam that I passed through?" I walked back to inspect it and they moved again. Then I realized the car had been turned off with the windshield wipers on automatic. But in the presence of a new situation that I didn't understand, my first impulse was to be self-referential.

Among biologically-oriented psychiatrists concerned with paranoia or schizophrenia, currently the emphasis is on neurotransmitters and neurochemistry. They may speculate about why patients do this or that action, but they are usually more concerned with why patients have obsessions than with the particular obsessions. Neurotransmission drugs and their effects, e.g., on dopamine, do not have to do with treatment of specific problems or actions. Why do patients repeatedly wash their hands, check the door or the stove, or have ideas of reference or persecution? More discussion is needed of the content as well as of the function and purpose of paranoia in specific cases.*

****Remark added by A.S. Luchins:***

With the drug approach, is there no place for psychotherapy to help the patient construct a livable world and take care of his everyday problems in the social field? My experiences indicate that drugs do not obviate psychosocial intervention which, moreover, can have the added dividend of helping the patient to comply with his drug regime. It is noteworthy that the biologically-oriented psychiatrist whose views were cited above believes that there should be more concern with the specific content of the paranoia.

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These papers were prepared as a contribution to the discussion in the psychotherapy section of the GTA about the SCHULTE theses on paranoia. They were translated into German by Gerhard Stemberger; this German version was published in *ÖAGP-Informationen*, 6 (1/1997), pp II-VII.