

# Double Bind: The Case of Jeremiah Green Schizoid Personality Disorder and Parkinson's Disease

by Autum Elizabeth Lum

## Abstract

*Individuals with mental illness are not immune to physical sickness and disease. However, little attention has been paid to the coping challenges and therapeutic treatment of those who suffer from this double bind. Of such studies that do exist, fewer still focus specifically on the unique challenges faced by older adults in this population. This paper presents the case of a 58-year-old man diagnosed with schizoid personality disorder and Parkinson's disease. The particular coping challenges he faces are addressed, as well as the clinical issues that emerged in the therapeutic treatment.*

## Introduction

Individuals with mental illness are not immune to physical sickness and disease. However, little attention has been paid to the coping challenges and therapeutic treatment of those who suffer from this double bind. Of such studies that do exist, fewer still focus specifically on the unique challenges faced by older adults and the elderly of this population. Indeed, the first study designed to assess the needs of older patients with schizophrenia was undertaken only recently, and documented only one other study that focused specifically on older psychiatric patients, most of whom were diagnosed with dementia and depression (Auslander & Jeste, 2002). The need for research on personality disorders in the older adult population has also been identified (Akhtar, 1987). In a descriptive study on schizoid personality disorder, Akhtar (1987) drew on Bergman's (1978) study of neurosis and personality disorders in the elderly in which he found that patients with personality disorders are able to adapt to the changing demands of old age better than might be expected. Although these studies are informative, their small numbers make clear the significant need for research on mental illness and aging.

This single-case study attempts to contribute to our understanding of the complex needs of older individuals who suffer from the double bind of chronic mental and physical illness by presenting the treatment of a 58-year-old man with schizoid personality disorder and Parkinson's disease. The client's particular coping challenges are addressed, as well as pivotal issues that arose during the course of treatment. In order to understand

the case more fully, brief discussions of both Parkinson's disease and schizoid personality disorder are presented.

## Parkinson's Disease

Parkinson's disease (PD) is a chronic, neurological, progressive and degenerative disease that affects approximately 1% of people over 55 years of age (Frazier, 2000). Although the incidence of the disease increases with age and onset is rare before the age of 30, PD can occur at any stage of life (Parkinson's Disease Foundation, 2003). In addition to physical symptoms, PD affects cognitive and psychosocial functioning as well. Physical symptoms manifest predominantly in the form of tremors, rigidity and slowness of movement in the limbs (Cummings, 1996). Typical cognitive problems associated with PD are memory impairments and dementia (Frazier, 2000; Cummings, 1996). Psychosocial functioning is often compromised by the many challenges posed by changes in physical appearance, social roles and interpersonal relationships (Kai & Crosland, 2002; Frazier, 2000).

Extensive research indicates a strong link between PD and depression, with approximately 25% of PD sufferers affected at some point (Cummings, 1996). In a recent article examining the relationship between PD and depression, Jeffrey L. Cummings states that depression can occur as the result of both psychosocial stressors and physical impairments to the brain stem region (Cummings, 1996). He reports that suicidal ideation is high among patients with PD, but few attempts are executed. Cummings notes that anxiety is common in PD sufferers as well. Drug therapy is often used to treat depressed patients, although these remedies sometimes exacerbate neurological symptoms and subsequently must be discontinued (Cummings, 1996). The physical symptoms of PD are treated with various drugs as well, all of which have potentially serious side effects, including urinary retention, constipation, blurred vision, nausea, insomnia, and in some cases, hallucinations and delusions (Cummings, 1996). For these reasons, it is essential that individuals with PD be monitored closely by their neurologists as well as their psychiatrists and other health care providers, such as social workers and internists, when appropriate.

## Schizoid Personality Disorder Through the Lens of Object Relations Theory

According to the DSM-IV-TR, the “essential feature” of schizoid personality disorder is “a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings” (American Psychiatric Association, 2000). In addition, diagnostic criteria requires the presence of at least four of the following: (1) neither desires nor enjoys close relationships, including being part of a family; (2) almost always chooses solitary activities; (3) has little, if any, interest in having sexual experiences with another person; (4) takes pleasure in few, if any, activities; (5) lacks close friends or confidants other than first-degree relatives; (6) appears indifferent to the praise or criticism of others; and (7) shows emotional coldness, detachment, or flattened affectivity (APA, 2000).

While this criteria establishes the formal basis for diagnosing schizoid personality disorder, the disorder is more complex than would appear at face value. In 1908, the term “schizoid” was first introduced by Eugen Bleuler (Akhtar, 1987). For Bleuler, the term indicated an intense, though non-psychotic preoccupation with one’s inner world. Since he introduced this concept, numerous theorists have expanded on its definition. Among various portraits of the disorder, a common feature is the tension between the schizoid individual’s contradictory inner emotional states (Akhtar, 1987). In addition, these states are considered to be defensively hidden behind a seemingly detached facade presented to the outer world. The consensus among theorists is that the inner emotions that are in conflict are a deep-seated longing for care and affection juxtaposed with a profound fear that if such love were received, one might consume it out of such hunger that the self of the giver of that love might be completely destroyed (e.g. Akhtar, 1987; Berzoff, 1996).

Object relations theory provides a solid base from which to better comprehend this tension (Applegate & Bonovitz, 1995). The theory is fundamentally concerned with the subject, or self, and how it relates to others as both people and as objects of desire, fear, or however the self perceives and experiences them. Object relations theory is rooted in the notion that relationship, or more specifically, attachment, is a basic and primary need. Psychological harm is thus born out of this need being inadequately met.

Donald Woods Winnicott focused on the complex dichotomy of the need for both attachment and separateness for healthy psychological development. Winnicott’s notion of the “holding environment”

pointed to a relational quality between the infant and caregiver (Applegate & Bonovitz, 1995). If the caregiver was “good-enough,” he or she would provide the infant with a sense of security, without being overly protective (Applegate & Bonovitz, 1995). However, if the environment was one in which the infant was neglected or, conversely, smothered, the infant would likely experience the caregiver as either rejecting or suffocating. There are multiplicities of ways in which important objects can be perceived. These perceptions ultimately dictate how one comes to know the world and oneself in it. The mind’s representation of both the self and others becomes the content of one’s internal world and lays the groundwork for later relatedness (Berzoff, 1996).

A significant contributor to the study of schizoid personality disorder, object relations theorist Melanie Klein, considered “splitting” to be the major feature of the disorder (Berzoff, 1996). Klein viewed splitting, that is, the division of self and object representations into two separate camps - good and bad - as a defense. The function of this defense is to ward off infantile anxieties that one might damage or destroy important objects through one’s intense neediness. Since the loss of such objects is feared, as is the fantasy that these objects might seek revenge, splitting becomes one of the major ways in which the individual with schizoid personality disorder is able to cope. When splitting occurs, the schizoid individual experiences others as fragmented, or “part objects,” instead of as whole people (Berzoff, 1996). Splitting is adaptive to the degree that it provides a way of managing, or sometimes controlling, incompatible aspects of the self and others when one is not able to synthesize them into a whole.

Adding to this discussion, W. R. D. Fairbairn asserted that by relating to others as less than whole beings, the schizoid individual often becomes exhausted by the challenge of social interaction (Berzoff, 1996). Since one fears the possibility of destroying others with one’s neediness, intimacy becomes frightening. Through projection of this fear, others come to be regarded as dangerous. For this reason, the schizoid individual tends to create ways of interacting with others that feel less threatening. Sometimes these efforts are translated into literary, artistic or intellectual pursuits – activities that allow the individual to express his or her needs and desires in a safe way. However, when feeling threatened and afraid, the schizoid individual attempts to create even more distance by appearing indifferent to others or even rude and spiteful.

Object relations theorist Harry Guntrip regarded fear as the primary characteristic of psychological distress (Berzoff, 1996). Excessive fear, he believed, creates a sense of being related diminutively to a terrifying world. In these terms, one feels powerless to cope with life in general, much less with the world itself. Guntrip attributed the etiology of schizoid personality disorder to one of three experiences in early life: 1) refusal of early caregivers to meet the infant's basic needs; 2) real physical threats from hostile objects; or 3) "emotional desertion by parental figures which necessitated seeking gratification within oneself" (Akhtar, 1987). Guntrip called the schizoid individual's simultaneous deep yearning and fear of closeness "love made hungry" (Berzoff, 1996). In addition to trying to protect important objects from destruction, Guntrip believed that this sought-after love is also rejected out of the schizoid individual's fear of being swept away in love's current, drowning any sense of autonomy.

According to object relations theory, treatment of individuals with schizoid personality disorder must begin with the therapist creating a safe space in which the client feels held, cared for and understood. In other words, the therapist must create a "good-enough holding environment." Among other things, the therapist can do this by providing his or her full attention to the client, being reliable and steady and, most importantly, by being open and empathic (Applegate and Bonovitz, 1995). For the individual with schizoid personality disorder, one of the major goals of treatment is to help her or him learn that it is okay to care about others – and to be cared for – without fear. To combat this fear, it is also critical for the therapist to be in tune with the client's alternating needs for closeness and space (Berzoff, 1996). When these experiences are adequately and consistently provided over time, the therapeutic relationship should provide the client with a new frame of reference – a new way to see him or herself in relation to another.

## Case Presentation

The following case is that of Jeremiah Green, a 58-year-old, Caucasian man with schizoid personality disorder and Parkinson's disease. Identifying information has been changed in order to protect the client's confidentiality. In September 2002, Jeremiah contacted the agency where I currently work as a second-year social work intern. He was looking for both case management and counseling services. He stated that he had been feeling extremely depressed and anxious regarding his health condition, to the point of

experiencing periodic suicidal ideation. After several sessions with Jeremiah, it appeared that his psychological symptoms fit the DSM-IV-TR criteria for schizoid personality disorder. The aim of sharing Jeremiah's case is to highlight some of the challenges that he has experienced in coping with the double bind of mental illness and the disabling disease of Parkinson's. Implications for the treatment and care of such individuals will be underscored as well.

Jeremiah was born in 1944 to a middle-aged couple who had been married for 11 years. He was the only child of his father and the second child of his mother (she had had a daughter sixteen years prior to Jeremiah's birth, but he had never known her because she had been placed for adoption). Jeremiah described his parents as "apartment dwellers" who moved frequently and never owned a home. Although his father owned a business, Jeremiah deemed him a "miserable failure" because he was unable to manage his money and "died with only \$300 in his pocket." His mother worked as a saleswoman to make ends meet, but the family always seemed to struggle financially despite her contributions. Although Jeremiah cared about his parents, he never felt close to them since they "worked all the time." To this he added, "I've had to fend for myself for as long as I can remember." In light of Guntrip's discussion on the causes of schizoid personality disorder, it could be argued that his parents' inadequate care was the genesis of Jeremiah's disorder. In the mid-1980s both parents died within a short period of time, leaving Jeremiah with no known living relatives and a sense that no one else in the world cared about him.

Growing up, Jeremiah had no close relationships with either relatives or friends. During high school some boys had tried to pressure him into "finding a girl to have sex with," but the anxiety this produced only resulted in him feeling more estranged from his peers. Jeremiah defended against this saying, "I never felt the need for friends anyway." Indeed, throughout college and up until recently, Jeremiah considered himself to be a loner with no need for friends. However, with the onset of Parkinson's disease two years ago, Jeremiah found it difficult to manage his needs without such supports. Naturally, this vulnerability has been extremely frightening for him.

The first signs of Jeremiah's Parkinson's disease manifested as slight tremors in his right hand and difficulty walking steadily. By March of 2001, he decided to retire early from his job as a pharmacist because he could not steady his hands to properly dispense pills. Although he misses his work, he does not believe that

anyone at the pharmacy where he worked misses him. This is evident to him in that, with one exception, none of his former co-workers have called to see how he is doing. For Jeremiah, this is further proof that no one cares about him.

At our first visit in September, he presented as disheveled and poorly groomed and avoided eye contact with me. Although mild tremors in his right arm were evident and he appeared to have some difficulty walking, he did not seem seriously disabled. During our session, I explained to Jeremiah that I was a social work intern and would be leaving the agency the following May. However, I assured him that he could continue with another therapist at that time if he so desired. Jeremiah stated that he would probably be dead by then, so he was not concerned about finding another therapist. Jeremiah then shared with me that he had been feeling depressed and isolated and he feared he might die soon due to his deteriorating health.

In order to better understand the severity of his health condition, I asked Jeremiah for more details. More specifically, I wanted to know what the diagnosing physician had told him regarding his prognosis. Although his neurologist had told him that he was in the early stages of Parkinson's, Jeremiah believed that his condition was much worse than the doctor was aware and that it was progressing at an unusually rapid pace. He stated that it was critical for me to understand the acronym TRAP, used to describe the symptoms of PD. That is, T for tremors, R for rigidity, A for akinesia (difficulty initiating movement) and P for posture instability. Although there are many ways in which to talk about Parkinson's, the acronym TRAP seemed to perfectly sum up how Jeremiah was really feeling, and he wanted to be sure that I understood this clearly.

For Jeremiah, one of the most disturbing aspects of the Parkinson's was the need to be dependent on others. He mentioned a pen pal, Janice, who he had been corresponding with for a few years. However, he was careful to point out that she had basically "abandoned" him after his diagnosis of PD. When I asked Jeremiah to say more about that, he explained that Janice was too pushy and "didn't give a damn" about his welfare. The next week he brought in a letter in which Janice had offered examples of things she had done to improve her quality of life; Jeremiah felt that Janice's letter indicated that she was "self-absorbed," but he said he would continue to write to her to give himself something to do. Over time, I have learned that Jeremiah responds best to empathic listening

above all else. As is the case with most people, he does not want me to try to solve his problems (as Janice was attempting to do). By providing an environment in which Jeremiah feels safe and held (the opposite of abandoned) he is able to work towards healing.

Throughout the course of treatment, Jeremiah has resided at the local YMCA. Prior to his stay there, he lived for a short time in a retirement community, which he found depressing because everyone was "old and senile." He was especially bothered by the fact that no one there could remember his name. During our first session, Jeremiah stated that he hoped to find a room to rent in a private home. He explained that he had lived in these types of home-share arrangements since college, but was currently having difficulty finding something suitable. He noted that his last home-share had been arranged by a woman named Dawn who ran an agency called New Beginnings that matched homeowners with renters. The arrangement did not last long because Jeremiah "didn't get along" with the homeowner. He told me that Dawn had taken the homeowner's side, claiming that "owners have the power;" and he didn't think that Dawn would be willing to help him out again. I questioned whether we should call her and request her assistance again, but Jeremiah was adamantly opposed. He stated that he would look for something on his own, but requested that I also offer him alternative options to consider.

Over the next several weeks, I presented Jeremiah with numerous housing options, including private apartments, shared housing, group living, nursing homes, assisted living facilities and various SROs (single room occupancies, such as the YMCA). For one reason or another, each suggestion was met with an objection and the statement, "there are no options." After a while I came to understand that what Jeremiah was actually saying was that there were no options that he was willing to consider, other than home-sharing. I brought up the option of contacting Dawn again, but Jeremiah was sure that she would be unwilling to help and admitted he felt powerless about gaining her support. Despite his reluctance, Jeremiah agreed to let me contact her. After several unsuccessful attempts to reach her by phone, I began to become suspicious myself. Perhaps she really would be unwilling to help. After leaving several messages, Dawn eventually returned my call and invited me to come with Jeremiah to her office in order to update his file. Considering Jeremiah's apprehension in dealing with Dawn and my own suspicions, I decided that such a visit would be a good idea. To my delight the visit went well and Jeremiah seemed more

hopeful than I had seen him in a long time. In fact, after the visit he carried himself more confidently and seemed to walk with less difficulty than normal.

Client advocacy and case management efforts like this have been an important part of my work with Jeremiah. Among other things, he has sought support from me in locating a Parkinson's support group and a lawyer to create a living will, as well as obtaining mail-order prescriptions and transportation assistance. While these concrete supports have been important, the most significant effect they have had on Jeremiah cannot be measured quantitatively. That is to say that this support has helped Jeremiah to feel as though he is a valued person worth caring about. For example, after our visit to New Beginnings, Jeremiah thanked me for my help and stated I was the first person in his life to have ever come through for him. In ways like this, our relationship is providing a new frame of reference for Jeremiah. He is learning that it is okay for him to be cared for and about – without negative repercussions.

However, throughout the course of our work together, Jeremiah has struggled with doubts about his worthiness and fears that his neediness will engulf those who try to offer him care. These feelings have been so troubling and intense for Jeremiah that he often sinks into suicidal pits of despair. One instance in which Jeremiah expressed such feelings of hopelessness occurred in response to my two-week holiday break in December. Per his request, preparations were made well in advance to have Jeremiah seen by another therapist while I was gone. In our last session before the break, Jeremiah stated he didn't know whether he could survive our separation. Even though he felt relieved to know that someone else would be available in my absence, he struggled with feelings that I must not care about him and was abandoning him. In response, my counter-transference manifested as guilt, but my studies in school and discussions in supervision about holidays and separations helped me to both understand what this meant to Jeremiah, and to trust that he would indeed survive.

When I returned from break, Jeremiah called to say he was glad I was back, but that his health condition had deteriorated significantly while I was gone. He requested that I come to his room at the YMCA since he was feeling too weak to come to the office but did not want to miss our session. Since our agency provides periodic home visits for invalids, this request was an appropriate one and I agreed to visit him at the YMCA. When I arrived at his room, he was feeling miserable and spent most of the session lying down

on his bed with a washcloth over his eyes. The following is part of our conversation during that visit:

J = Jeremiah; SWI = Social Work Intern

J: I'm sorry that you have to see me like this.

SWI: Don't worry about me – I'm fine. I just want to make sure that *you're* okay.

J: That means a lot to me. But it's hard for me to be like this. I've always been a loner and never needed anyone.

SWI: It's okay to need people. Everybody does at one point or another in life.

J: But I don't even feel like a man anymore – I'm turning into a vegetable. *<Begins to cry>*

SWI: I know that you're not as healthy as you used to be, but you're still a man.

J: I used to be a gentleman. I never used to curse and now I do it all the time. You shouldn't have to hear me talk like that.

SWI: It's only natural to be like that when you don't feel well. You can talk any way you want to with me and I won't think less of you.

J: I just don't understand why I have to suffer like this. I've been asking God for a sign, but nothing ever comes. And every day I pray: Even though I walk through the valley of the shadow of death... *<He recites the rest of the 23rd psalm while sobbing>* I just don't understand why God is letting me suffer like this!

SWI: That's a really hard thing for anyone to understand.

J: I don't know if I'll go to heaven.

SWI: Does that worry you?

J: A little bit... I'm just afraid of so many things. I want to show you something.

SWI: Okay.

J: *<Sits up and reaches for a piece of paper next to the bed.>* Here, this is what I wrote at the library yesterday:  
I am afraid to drive  
I am afraid to pay my bills  
I am afraid to stay in my room at night  
I am afraid to talk to Dr. Ziegler  
I am afraid to eat out  
I am afraid to talk to the desk clerk at the

YMCA

I am afraid to take my medicine  
 I am NOT afraid of dying  
 I am afraid I will die like my mother, *alone with nobody to care\**  
 I am afraid I will go broke  
 I am afraid to walk  
 I am afraid to talk to people  
*I am afraid people don't care about me\**  
 I am afraid that I will fall and hurt myself  
 I am afraid to brush my teeth  
 I am afraid of any noise  
 I am afraid to return my library books  
 \*Italics added for emphasis.

SWI: This is quite a list. <Reading it over> When you say that you're afraid to pay your bills or return your library books or brush your teeth, do you mean that you're afraid that you won't be able to do those things because of your illness?

J: Yes, that's exactly what I mean.

SWI: I noticed that you also wrote that you're afraid that people don't care about you and that you're afraid you'll die alone like your mother.

J: Yes, I wouldn't worry about the other things as much if I had a caregiver, but I'm all alone. <He starts crying> I don't think I ever told you about how my mother died, did I?

SWI: Not exactly. You told me that she went into a nursing home and died there.

J: Yes, but it's the way she died.

SWI: Can you tell me about it?

J: She fell down in her room and nobody noticed right away. I don't know how long she lied there without anybody to help her up – it could've been hours. Finally, someone found her and they called me. So, I went out there right away...<starts crying harder> When I got there I went up to her and said – “Ma, it's me, Jeremiah. I'm here now.” But all she did was go...”uuhh...” <makes a grunting sound>. Then the nurse came in and told me not to bother because she was brain dead. They told me that she was in a coma and asked me what I wanted to do. I told them that she didn't want to be kept alive on machines. So they told me they would just monitor her and call me when she died.

SWI: That must've been really hard for you. You

didn't even get a chance to say goodbye to her.

J: Yes, it was terrible. But, the worst thing was waiting for her to die. Every time the phone rang I wondered if it would be the hospital calling to tell me that she had died. It took two weeks. It was the longest two weeks of my life. <starts sobbing and talking louder> I'm afraid that I'm going to die like my mother! God, No! I'm going to die like my mother! All alone! <He was crying so hard when he said this that he kept gasping for air.>

After assuring Jeremiah that he was not alone and that I cared about him, he was able to regroup and seemed quite relieved. The session was pivotal in that Jeremiah had grown to feel safe enough with me to disclose deep emotions and cry out for help. But Jeremiah's list of fears was presented above in its entirety in order to illustrate how frightening it is for him to face the challenges of Parkinson's in light of his mental illness.

The session was also particularly draining for me, since Jeremiah's helplessness reminded me of what my grandfather had gone through in his struggle with Alzheimer's disease. In addition, his theological questions around the meaning of his illness aroused strong feelings in me since I am a divinity student, as well as a social work student. However, as his therapist, I was determined to let Jeremiah work out those feelings in his own way. Processing this experience in supervision was critical for me and helped me to sort through the strong feelings that Jeremiah had evoked in me.

Perhaps the issue that most consumed Jeremiah's thoughts over the course of our treatment was his healthcare. During our first session, Jeremiah complained incessantly about his neurologist, Dr. Ziegler. Although he felt that his health was “deteriorating rapidly,” he didn't feel as though this was taken seriously by his doctor. He explained that he could talk until he was “blue in the face,” but would never get a satisfactory response. He was especially put off by what he called Dr. Ziegler's nurse's “condescending manner.” He described this as insincere flattery and dishonesty (e.g. statements like, “You're doing great!” which Jeremiah found demeaning). When I spoke with the nurse I found her to be quite warm and accessible. She informed me that most patients in Jeremiah's condition only needed to be seen a few times a year, but that Dr. Ziegler had been willing to see him almost once a month per Jeremiah's request.

Over time I tried to assess what bothered Jeremiah most about his healthcare. Was it his physical state or the fact that he did not feel listened to? At one of our visits I asked him to explain how he had felt when he first went to see Dr. Ziegler. He responded, "The day I walked into that office was the day the first nail went into my coffin." When I asked him to elaborate, he said, "There is a total lack of understanding in that office." He added that he felt as though Dr. Ziegler was a "cold, calculating, inhumane man." Jeremiah felt that Dr. Ziegler had promised to help him, but hadn't come through. When I asked him what "coming through" meant to him, he responded, "You have to be near death to speak to him...and his nurse, that son of a bitch is the guardian of the gate - she won't give you the time of day either!" During one session, Jeremiah confessed having fantasies about killing Dr. Ziegler. In response to my questions about the sincerity of those sentiments, Jeremiah stated, "Actually, I wouldn't really want to kill him. But I'd like to scream and yell at him. I'd probably get so upset that they'd have to sedate me."

As I listened to Jeremiah's feelings over time, I came to believe that Dr. Ziegler was a capable physician with perhaps an unfortunate bedside manner. It seems that what bothered Jeremiah most was Dr. Ziegler's inability to reflect Jeremiah's concerns in an empathic way. For this reason, I encouraged Jeremiah to seek out a new neurologist. In exploring the subject, I asked him to suppose that he could find another doctor. What would he hope his treatment to be like with someone else? Jeremiah's first response was, "You're really dealing with insurance companies, not doctors." Despite this answer, I pressed him to think about what qualities he would want in a doctor. Finally, he said that he would want a doctor with "a little compassion." To this he added, "Dr. Ziegler sees poor puny me and thinks it's okay to push me around...he doesn't care."

In January, Jeremiah was admitted to the hospital by his psychiatrist after expressing great anxiety over the state of his health and his inability to cope with the stress. This was his second psychiatric hospitalization within approximately a year. Upon discharge a few days later, Jeremiah was released to a nursing home for a brief respite stay. When I spoke to him in the hospital, he promised to call me from the nursing home when he got settled. After a few days had passed and Jeremiah had not called, I decided to go ahead and contact him myself. When I reached him he explained that he hadn't called since going into the nursing home because he felt that he was becoming a

burden. "I was afraid that you would leave me or desert me," he said. I reassured him that I cared and that he had not become a burden to me.

The following month, Jeremiah got up the courage to see a new neurologist. This move was fraught with anxiety as Jeremiah worried excessively about whether this new doctor would be "just as bad as Dr. Ziegler." He also worried that this new doctor would be "afraid of Ziegler's power...afraid to contradict him." This was likely a projection of the way in which Jeremiah felt in relation to Dr. Ziegler. Finally, he worried about going to the appointment alone. In discussing these fears, Jeremiah seemed to obsess about the issue of transportation. He told me that he didn't want to take a train because he would have to walk too far between stops, and he didn't want to take a taxi because it would be too expensive. It seemed that everything I suggested was met with an objection. Finally, Jeremiah became angry and said, "So I guess you're obviously not going to take me." Out of this, we were able to discuss Jeremiah's fears that he would not be listened to or taken seriously if I was not there. I asked him why he felt that a caregiver would be listened to, but that he would not. Jeremiah asserted that while he always feels misunderstood, he was "10 million times sure" that I would be taken seriously. As an example, he cited the fact that I had helped him communicate with Dawn at New Beginnings. Although I felt immense pressure from Jeremiah to accompany him to his appointment, I also felt that doing so would start to muddy the waters between therapist and friend. I even began to doubt whether I should have gone with him to New Beginnings. We finally found a middle ground that seemed to work for both of us. He would go to the appointment on his own, but I would call the doctor prior to his visit to inform her of his concerns about being listened to and taken seriously.

At the session following his appointment, Jeremiah was extremely hostile and expressed suicidal ideation. When he first entered the office, his voice was so quiet that it was barely audible. As the session progressed, however, he became more and more agitated and began to yell. He said that he did not wish to discuss his appointment with the neurologist and that he was disgusted with me because "no progress [has] been made on anything since we began working together!" He was on such a rant that it was almost impossible for me to interject. When I managed to say something, Jeremiah barked, "I don't believe that you care! You're leaving in May!" He told me that everyone in his life, including me, had "deserted" him.

When I asked about this, he said he was very upset that I had failed to find transportation to his appointment and he began demanding that I find something affordable for his return appointment in two weeks. When I asked him whether he was feeling upset with me for not going with him to his appointment, he became even more enraged and yelled, "No! That's not it at all!" Following this he began threatening suicide, arguing that his doctors and I would probably be relieved to see him dead so that we wouldn't have to deal with him anymore. I eventually established with reasonable certainty that Jeremiah would not hurt himself in the near future and decided to bring the session to a close.

Later that day I left a voicemail message reassuring Jeremiah that I indeed cared about him and promising to call back later that same evening. When I reached Jeremiah later that night, his voice was almost inaudible again. I believe this reflected Jeremiah's sense of being small and insignificant in relation to a frightening world. He immediately apologized for being "belligerent" with me earlier, and claimed that an imbalance in his Parkinson's medications had made him act that way. I assured him that it was okay for him to feel angry with me and to express those feelings when they came up. The following week, our last session at this writing, Jeremiah came into the office carrying the book, "When Bad Things Happen to Good People." The first thing he said when he saw me was that he wanted to read a paragraph from the book out loud. It went as follows:

Human beings are God's language. That is, when we cry out to God in our anguish, God responds by sending us people. Doctors and nurses work tirelessly to make us whole. Friends come and sit with us, hold our hands without speaking, without trying to explain away our suffering or diminish it by telling us of other people who have it worse. And though we did not know it, that is exactly what we need, the reassurance that we are not alone and that we are people worth caring about.

In reading this excerpt, Jeremiah was able to express his gratitude and tell me how much I have meant to him in a way that felt safe. The passage also sums up what I believe is the most critical aspect of therapy with "double bind" clients like Jeremiah. That is to say that what people who face such challenges need most is to know that there is someone out there who cares about them and is willing to listen. That person may not be able to physically heal their afflic-

tions, but can offer them a relationship experience that provides healing of an equal, if not greater, significance. As this study concludes, my work with Jeremiah continues. I suspect that termination will be difficult for both of us, but I hope that our relationship has given Jeremiah something to hold on to – the belief that he is worthy of being cared for and the knowledge that love is not dangerous.

## References

- Akhtar, S. (1987). Schizoid personality disorder: A synthesis of developmental, dynamic, and descriptive features. *American Journal of Psychotherapy*, 16 (4), 499-518.
- American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders, text revision. (4th Ed.). Washington: American Psychiatric Association.
- Applegate, J. and Bonovitz, J. (1995). *The facilitating partnership: A Winnicottian approach for social workers and other helping professionals*. Northvale: Jason Aronson Inc.
- Auslander, L. and Jeste, D. (2002). Perceptions of problems and needs for service among middle-aged and elderly outpatients with schizophrenia and related psychotic disorders. *Community Mental Health Journal*, 38 (5), 391-402.
- Bergman, K. (1978). *Neurosis and personality disorder in old age: Studies in geriatric psychiatry*. New York: John Wiley & Sons.
- Berzoff, J., Berzoff, L. and Hertz, P. (1996). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts*. Northvale: Jason Aronson Inc.
- Cummings, J. L. (1996). What is the relationship between Parkinson's disease and depression? *Harvard Mental Health Letter*, 12, (9), 1-2.
- Frazier, L. (2000). Coping with disease-related stressors in Parkinson's disease. *Gerontologist*, 40 (1), 1-13.
- Kai, J. and Crosland, A. (2002). People with enduring mental health problems described the importance of communication, continuity of care, and stigma. *Evidence-Based Mental Health*, 5 (2), 1-2.

Kushner, H. (2003). *When bad things happen to good people*. New York: Schocken Books.

<http://www.pdf.org/AboutPD/>  
(Accessed February 23, 2003, 6:15 p.m.).

Parkinson's Disease Foundation. Internet Resource:

---

*Autum Elizabeth Lum received her MSW from the School of Social Work in May 2003. A dual-degree student in social work and ministry, she will graduate with a Masters of Divinity from McCormick Theological Seminary in May 2004. Her first-year internship in clinical social work and ministry was at Interfaith House, a respite and rehabilitation center for homeless adults recovering from illnesses and injuries. In her second-year social work internship at a counseling center in Chicago, she provided individual, couples, and group counseling to children, adolescents and adults. This paper received 1st place in the School of Social Work Distinguished Writing Awards 2003.*