INTERPRETATION OF SCHIZOPHRENIA

Psychodynamic Analysis

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I
Introduction

Psychodynamic analysis starts to some extent at the very beginning of treatment. However, as we have seen in the two previous chapters, the early stages of therapy are predominantly concerned with the establishment of relatedness, with the phenomena of transference and countertransference as lived experiences, and with special attempts to solve the structure of some psychotic mechanisms.

Psychodynamic analysis of the schizophrenic consists of interpreting to the patient his past and present life. He is helped to become aware of his unconscious motivation and to acquire insight into the origin and development of the psychological components of his disorder. This part of psychotherapy becomes the major one when relatedness is more or less established and at least some of the prevailing psychotic mechanisms have abated or have disappeared.

There are some technical difficulties in giving a detailed

illustration of this part of the treatment. In the first place we would have to repeat what was studied in the whole of Part Two of this book. In the second place, some of the psychodynamic interpretations apply also to patients belonging to other psychiatric categories and are already known to the reader. In the third place we have the problem common to every psychodynamic study: every case is psychodynamically different and is the result of a particular set of circumstances. Thus the study of previous cases has definite but only relative, not absolute, pragmatic value. In this chapter we shall discuss basic situations that are likely to occur in many cases. Again I have to draw from some of my previous writings (Arieti, 1955, 1957, 1968a, 1968c, 1971a).

Contrary to what is believed by many, schizophrenics do not have insight into the psychodynamic meaning of most of their symptoms. Interpretations are thus necessary when these patients are ready to accept them. As we have already mentioned, the therapist gives interpretations while the patient is still, metaphorically speaking, in the dream of the psychosis. The interpretation will be useless (1) unless it will be integrated in a context of relatedness (the patient is not alone in the psychotic dream); (2) unless the emotional content

and meaning are shared by the therapist; and (3) unless it will be given in a simple and clear language that appeals to the primitive as well as to the elevated levels of the psyche.

II
Analysis of Relations with Members of the Family

The importance of the original relations with parents, parent-substitutes, and other members of the family will unfold gradually during the psychodynamic analysis. If the therapist calls his attention to it, the patient may realize even from the very beginning of the treatment that what the voices say has a strong similarity to the ideas he once attributed to the important people of his past. In the beginning of treatment the parental role is generally shifted in a distorted way to the persecutors. In a minority of cases it is displaced not to persecutors but to supernatural, royal, or divine benefactors, who, in these grandiose delusions, represent figures antithetical to the parents. In a certain type of patient, one who used to be more common in the past and may become more common again, at the beginning of the treatment the parents themselves are seen as saviors, angels, benefactors. The patient, who is frightened of the world and feels still

so dependent on the parents, has the need to see them (more frequently the mother) in that extremely positive way. Any negative quality that the parent may possess is displaced to the persecutors.

The majority of psychotic patients never see their parents in this light. After the initial stage of treatment, during which the patient focuses on the persecutors or other aspects of his symptomatology and sees the parents in a neutral way, he discovers the importance of childhood and of his relations with mother and father. He then develops another attitude toward them. The original parental image comes to the surface, and he attributes to the parents full responsibility for his illness and despair. As we have seen in Chapter 5, even many analysts and psychiatrists have accepted as real insights, and as accurate accounts of historical events, these explanations given by patients. It was easy to believe in the accuracy of the patients' accounts, first of all because some parents do fit this negative image; secondly because the patients who had shifted their target from the persecutors to the parents had made considerable improvement, were no longer delusional or delusional to a lesser degree, and seemed to a large extent reliable.

The therapist must be careful. In a minority of cases the parents have really been as the patient has depicted them. In by far the majority of cases, however, the patient who comes to recognize that the parents have played a role in his psychological difficulties exaggerates and deforms that role. He is not able to see his own deformations until the therapist points them out to him. In many cases it is very difficult for the therapist, too, to distinguish what was neurotic, psychotic, or malevolent in the parents from what the patient has superimposed. The two parts often blend and coalesce. Fortunately some circumstances may help. In his newly developed antiparental zeal the patient goes on a campaign to distort even what the parent does and says now. Incidentally, this tendency is present not only in schizophrenics but also in some preschizophrenics who never become full-fledged psychotics. By being fixated to an antiparental frame of reference they may not need to become delusional and psychotic. To a much less unrealistic extent this tendency occurs in some neurotics too. At times the antiparental campaign is enlarged to include parents-in-law and other people who have a quasi-parental role.

The therapist has to help in many ways. First, he points out how

the patient distorts or exaggerates. For instance, a white lie is transformed into the worst mendacity, tactlessness into falsity or perversion. These deformations are caused by the need to reproduce a pattern established in childhood, a pattern that was the result not only of what happened historically but also of the patient's immaturity, ignorance, and misperception. At times these deformations are easy to correct. For instance, once the mother of a patient told her, "Your mother-in-law is sick." The patient interpreted her mother's words as if they meant, "With your perverse qualities you have made your mother-in-law sick as you made me sick once." Another time the mother asked what the patient was making for dinner. The patient interpreted mother's remarks as criticisms. Mother intimated that she was not a good cook or did not know how to plan a meal. On still another occasion the mother spoke about the beautiful apartment that the patient's newly married younger sister had just furnished. The patient, who, incidentally, was jealous of the mother's attention for her sister, interpreted this remark as meaning, "Your sister has much better taste than you."

In the second place, the patient must be helped to realize that the negative traits of parents or other important people are not

necessarily arrows or weapons used purposely to hurt the patient. They are merely characteristics of these people and should not be considered total qualities. For instance, in the remarks of the mother of the patient, which we have just reported, there might have been some elements of hostility. As a matter of fact, one may think that the patient was not only distorting but was very close to the truth, because she became particularly sensitive to her mother's hostility—hostility that the world at large wanted to deny. If the therapist also denies this hostility, he may appear to retrogress to a nonpsychodynamic approach. The situation is often reminiscent of a Pirandellian drama, in which we do not know who is right and who is wrong. The distinction is more difficult when we do not deal with definite delusions but with distortions. A distortion is based on reality, but the proportions or the various ingredients of the reality situation are altered. We must tell a patient like the one we have just referred to that we recognize that she may be correct in some particular aspects of her mother's communication. Yes, there might have been more than an element of hostility in mother's remarks, elements of which the mother might not have been aware. The patient might have acquired what in Chapter 37 has been described as punctiform insight. This

insight, although important, concerns only one aspect of mother's attitude.

In every human relation and communication, in every social event, however, there are many dimensions and meanings, not only in the so-called double-bind talk of the so-called schizophrenogenic mother. But the patient focuses on this negative trend or aspect and neglects all the other dimensions of the rich and multifaceted communication. The patient is unable to tolerate any ambivalence, any plurality of dimensions. Treatment must help him to accept this plurality as inherent in human life.

Third and most important, the therapist must help the patient to decrease the impact of the parental introject. The patient is an adult now; it is up to the patient to provide for himself or to search for himself what he once expected to get from his parents. The patient shows considerable improvement when the original parental introject has been transformed, when he has understood how he came to build such negative parental images (see Chapter 5). His changed attitude toward his parents will be revealed especially by his dreams, as we shall see in the last section of this chapter. As long as the patient has

not been able to solve in one way or another his conflicts with his parents, he remains vulnerable to the psychosis.

Many patients come to realize that some of the worst things their parents have said or done should not be interpreted as signs of total or constant rejection but as expression of a temporary state of exasperation, partially caused by the patient himself. Some patients shift their animosity from the parents to all adults or to society at large. At times it is difficult to recognize below a grudge that may even seem justified a need to converge hate toward other people in authority, parental role, or who somehow were conceived as hampering the spontaneous wishes of the patient.

At an advanced stage of treatment the patient will recognize not only how much he distorts now and in the past, but also how much his distortions facilitated the subsequent development of his illness. His misconceptions became additional causes of abnormalities and deviations.

III
Special Delusional Mechanisms

The mechanism of projection, to which we have referred several times in this book, is very commonly used by the patient and can be explained to him both from a formal and from a psychodynamic point of view. We may explain to the patient that he attributes to the external world certain ideas about himself that he himself entertains but is unwilling to admit. If he hears voices of persecutors calling him a spy, a homosexual, a thief, it is because *he* has or had a very disparaging opinion of himself. These accusations that he attributes to others are exaggerations or distortions of the original self-accusation. We have seen in Chapter 37, however, that this explanation of the projection mechanism is not effective unless the patient comes to see that he himself passes a negative judgment on himself and unless we help him to change this self-evaluation.

The explanation of the projection mechanism often requires reevocation of what occurred in childhood and adolescence. For instance, it is useful to explain to some paranoids, in a language that they can understand, that their feeling of persecution is also a reextemalization of the hostile feelings that they experienced in early childhood and that the later experiences of life have exacerbated. In some instances I found it useful to explain to the patients that their

feeling that their thoughts were being controlled by an external force was a reactivation and a concrete representation of the feeling that they had in early childhood that their thoughts were being crushed or controlled by those of the dominant adults.

The specific content of some delusions can be easily traced to early life experiences. During a psychotic episode a patient in his early thirties believed that he had the power to control the world, make the human race perish, and replace it with a population of dogs.

This patient lost his mother at the age of three. He was brought up by two much older sisters, who resented having to take care of him, and by a father who was a "perfectionist." Because of his own frustrations the father was unhappy and hard to please. In order to stimulate the patient toward constant improvement the father provoked great anxiety in his son, who came to believe he would never succeed in anything he tried. When the father remarried, the stepmother was perceived by the patient as a caring person at first, but hostile later and a source of sexual stimulation from which he could not escape. The poor communication, the inability to ventilate properly the problems and the resulting anxiety, predisposed the

patient to think that the father would always find fault in him and would never love him. And yet love from the father was what the patient wanted most. Nothing could be more precious or more difficult to attain. Was there in the world a creature toward whom the father was lenient, not demanding, and on whom he bestowed love? Yes, the dog of the family, or rather the series of dogs that succeeded one another. When the patient became delusional, he changed from a state of hopelessness and worthlessness into a position from which he felt he had the power to control or transform the world. The new world would be populated not by people who withdraw love but by those who could obtain love: the dogs. When the acute phase of the episode was over and the patient was able to give a detailed personal history, he was easily helped to trace back the origin of his delusions. It was also explained to him that the original relations with the father, although unhappy and unhealthy, were already unrealistically transformed in childhood and made worse by poor communication, inability to see the totality of the picture, difficulty in finding compensations, and especially by the tendency to experience the rapport with the father in a restricted and unfavorable way. As we have already mentioned, the relation with the stepmother proved to

be a difficult one and in its turn made the relation with the father even more complicated because of a new and rather late Oedipal situation.

In some cases it is difficult to explain the projection mechanism because it is connected with some realistic problems of the patient. In these instances we do not have the punctiform insight, described in Chapter 37, but a further deformation of reality because of the realistic connection. An example will serve as an illustration. Justin, a patient in his early twenties, experienced the following phenomenon: he was hearing a man (whom at times he would consider an impostor, at other times "another self") say profane things. Justin felt that this other person was using his—Justin's—mouth and his voice so that people would actually think it was just Justin who was talking. This man would utter embarrassing words with homosexual content. For instance, he would say, "I like cocks."

The fact was that Justin *was* homosexual and had had some overt homosexual experiences. As is common among homosexuals, a part of him wanted to reject homosexuality because it was unacceptable to society. Another part of him admitted frankly that he enjoyed homosexual life. He was unable to suppress or repress this latter part:

he thus projected it. The impostor was divulging the news and was using the patient's mouth. Justin was told how he was divided on the issue of homosexuality and that if he would accept either his ambivalence or his homosexuality, he would not need to resort to this strange phenomenon.

The part of the patient that is determined to reject the wish is either representative of society or of the parents. Often we are successful in explaining to the patient that the negativistic or ambivalent attitude is a persistence of the original oscillation between the parental wishes and his own.[1]

IV
Psychodynamic Analysis of Relatedness, Transference, and Countertransference

Whereas at an early stage of treatment relatedness and transference were important almost exclusively as lived experiences and did not require interpretation, at a certain stage of the treatment they do. The fear, the mistrust, the experiencing of others as monstrous powers and of the world at large as an unbearable pressure from which the patient wants to withdraw in order not to be crushed,

are discussed at an advanced stage of treatment. All these explanations have to be made with extreme cautiousness, lest they evoke a reaction that is the opposite of what we want. In fact, the patient withdrew not only physically but also emotionally, and actually developed means of desocialization (see Chapter 19) in order to avoid these unpleasant facts. At first it would thus seem that we want to make him aware of what he cannot bear, thus facilitating his desocializing and withdrawing tendencies.

Again we must take into consideration that at this stage of the treatment a certain amount of relatedness and trust exists. What we offer is not just an interpretation but also a feeling of understanding and willingness to share some views of the world and to correct others. All the family situations that we have described in detail in Part Two will receive full consideration, description, and understanding. We must help the patient to become aware not only of the past but also of the present needs and psychological structure that confer a particular experiential form to his transference or relatedness in general. Whereas early in life the patient shaped his relations with the world according to deformed parental patterns, now, if treatment is successful, in relating to the world he is influenced by the

transferential pattern. But the transferential pattern, in order to be beneficial, must not be distorted by psychotic trends, and only to the minimal irreducible extent should it be distorted by the old parental pattern.

The developments that we have described in Chapter 36 must now be verbalized and discussed with the patient. It would be redundant to repeat them here. We shall discuss a few more. The therapist will gradually change his attitude toward the patient as the patient improves. From being so giving and maternal he becomes more demanding and paternal. The patient may resent this attitude and may claim that the therapist has changed and is no longer so helpful. Now he is like the others; now he does not care for the patient any more; he makes excessive demands. The therapist must point out to the patient that the demands made on him are a proof of his improvement, of the faith put on him, a recognition that now he can face the world without fear, or at least with less fear.

Of course, demands must be made very slowly, especially on patients who had a symbiotic tie to the mother or mother-substitute. Growing may be experienced as cruel separation, acute realization of

excessive dependency, and the end of a vital symbiosis. The therapist must restrain his desire for fast progress lest the patient's longing for the old symbiosis precipitate a relapse.

When the treatment is protracted for a very long time, two countertransferential situations may occur that are almost antithetical. The therapist may have become so used to treating the patient that he is not aware of his improvement. The routine of the treatment has become such an important part of the therapist's life that he does not recognize that sessions have to be curtailed. The therapist may not even recognize at times that the patient is ready for discharge. He must pay serious attention to any request on the part of the patient to decrease or end the treatment. Although it is true that often patients are eager to terminate treatment prematurely, it is also true that some therapists eventually believe that they are always indispensable to patients who used to be very sick. There is a part of the therapist who enjoys being a benefactor. His narcissistic needs are gratified by associating with a person who has benefited so much from his intervention. Also, it is difficult for him to face the emotional deprivation caused by not seeing any longer a person toward whom he felt very close and on whom he invested affection and devotion for a

long time. In other words, the therapist must always be aware of his countertransferential feelings. If he cannot recognize them, he has to resort to the help of a colleague or of a supervisor. When the countertransferential feelings are known to the therapist, they reveal a great deal about the therapist as well as about the patient who elicited them.

The second situation we have referred to may have worse consequences. The therapist is so used to the patient after having seen him so often and for such a long time that he no longer is able to recognize the patient's pathology, especially if he has a strong liking for him. He is so used to the patient's projective mechanisms, peculiar ways of thinking and talking, that he no longer recognizes them as abnormal or strange. The result is that a patient who would immediately appear very ill to a new therapist does not seem so to the original therapist. In some instances it is difficult to evaluate whether this situation is the result purely of habituation, reminiscent of that of some relatives who are so used to the peculiarities of the patient as to be able to overlook them, or whether other factors enter. Both in the cases of the therapist and of the relatives there may be a desire not to see for different reasons.

Less frequent, but frequent enough to be considered, is another countertransferential complication. Many therapists are deeply and seriously interested in schizophrenic patients as long as the latter show schizophrenic symptoms. These therapists have a very deep scientific or humanistic interest for *folie.* When the patient no longer presents schizophrenic symptoms, he appears like a simple neurotic, and the therapist may not feel so deeply committed or interested in his complete recovery. Some patients have been able to detect this change in the therapist. Whereas at first this change seemed a projective mechanism on the part of the patient, it revealed itself to be realistic in supervisory discussions and was corrected. In some cases it was necessary to understand why only the obviously psychotic patient would be of interest to the therapist.

Needless to say, the therapist in training must be made aware of the danger of these countertransferential complications and must learn to correct them.

V
Interpretations Related to the Self-Image

Unless the patient changes his vision of himself, he is not likely to

lose his psychosis or the potentiality for the psychosis. Interpretations are very useful in this respect. How the psychotic sees himself is often revealed in the most primitive, bizarre, and concrete ways by his dismorphophobic delusions or dysmorphic ideas: he is very little, his face has changed aspect, his head is flat or empty, he has lost his heart, injured his brain, his blood has dried out, his genital organs have undergone metamorphosis. He stinks, gas is emitted from his body constantly, and so forth. In most cases, however, the self-image does not receive such a clear-cut concrete representation.

The self-image is so terrible that the patient wants to hide it not only from the world but from himself. He generally tries to bargain by accepting a self-image that is also terrible, but not as terrible as the original one. We have already seen several times in this book how even some delusions and hallucinations that give the appearance of being very painful are attempts to protect the self-image (Chapter 8). As bad as it is to be accused by others, it is better than to accuse oneself.

If the therapist has succeeded in establishing relatedness and in exchanging some warmth, which is not mistrusted, the patient will

have less need to keep the self-image secret from himself or projected and distorted by means of delusions and hallucinations. We must reaffirm to the patient that we agree with him that his life has been discouraging. His discouragement has been intensified by his way of seeing the world. By adopting different ways and with a feeling of hope, life may unfold in a more rewarding manner. From the way the therapist has treated him, the patient will recognize that his human dignity has been respected, that the therapist does not consider him a curious specimen in an insane asylum, one who is incomprehensible to others. It is because the patient thinks so little of himself that he has to defend himself so tenaciously. Yes, there is some truth in what he says about the others. They have minimized and belittled him. The others have not recognized his values, but he has not helped them to do so.

In discussing the establishment of relatedness in Chapter 36, we have discussed the role of reassurance. But whereas the reassurance given at the beginning of the treatment was that of a person who wants to give, understand, and share the patient's burden, the reassurance given at a much more advanced stage of treatment depends on the reinterpretation of the self-image. The patient's destructive anxiety, rooted in his early life experiences, had compelled

him to see himself in a horrible way, in a way that would explain the complete discouragement about himself.

If there are particular reasons why the patient has sustained a tremendous injury to the self-esteem, of if there are particular factors in the life history that are responsible for a development of a weak self-image, they have to be discussed and clarified. Homosexuality or lack of sexual identification may be among such factors. At times the complexes have to do with special or impossible roles that the patient thought he had to play in life.

Mario, an Italian patient, was the son of a well-known patriot and writer who had been killed by the Fascists. The patient grew up in an atmosphere where the mother, overwhelmed by the tragedy in her life, had not been able to fulfill an adequate maternal role. The patient grew up with the feeling that mother did not like him and considered him inferior and unlovable. Different, however, was the feeling he received from the paternal grandmother, who thought little Mario would grow up to be as great as his heroic father. Mario would be a writer, a great painter, a great leader, and so forth. When the patient, later in life, felt unable to carry the burden of living up to being a

duplication of his father and of fulfilling his grandmother's aspirations, which had become his own, he was more prone to accept the image of himself that he thought his mother had of him. These two self-images produced inconsistency and doubt in him and, either in conjunction or separately, were the psychodynamic factors that led him to psychosis. He had to be gradually helped to abandon both these images and to see himself in a different way.

VI
Dreams

Interpretation of dreams also plays an important role in the psychotherapy of schizophrenia. Of course, because the study of dreams requires a high degree of participation on the part of the patient, such study cannot occur until relatedness has been established and the symptomatology no longer interferes with the necessary cooperation.

Authors have reported contrasting findings. Noble (1951) has found primitive ideation, with free and undistorted expression of destructive and incestuous drives. Richardson and Moore (1963) have reported an interesting study. Their expectation was that the dreams

of schizophrenics would reveal less distortion and less censorship than those of nonschizophrenics. Their study did not disclose that this was the case. Primitive aggressive dreams (including bodily mutilation) and undistorted sexual dreams (including incest) occurred with no more frequency in the schizophrenic than in the nonschizophrenic group. The authors felt that the first significant finding in their study was that repression (or censorship) appeared to be approximately as effective in the dream work of the schizophrenic as in the nonschizophrenic. Their second significant finding consisted of the quality of uncanniness, bizarreness, and strangeness of many (but not all) schizophrenic dreams.

Ephron (1969), reporting on studies made in collaboration with his wife Patricia Carrington, compared dreams of thirty schizophrenic and thirty nonschizophrenic women whose average age was 19 years. He reported that the nonschizophrenic dreams tended to be practical, realistic, and detailed, often relating experiences from waking life. By contrast, schizophrenic dreams seemed stark and tragic. Detail was minimal and was subordinated to tense drama. They were aggressive, bizarre, replete with mutilation, and the persons depicted in them were overwhelmingly threatening. According to Ephron, in dreams of

normal people the “element of searching, of reaching for security, for the familiar territory, for an orientation to one’s self, seems a paramount drive during sleep as during waking life. This search can be seen to commence at the beginning of almost any dream and work its way persistently through until the end. And it will be more or less successful according to the personality of the dreamer, the time of night, and other factors which may influence the eventual outcome of such an endeavor.” There are no constructive elements in schizophrenic dreams, according to Ephron. Even when bizarre imagery, mutilations, brutality, devastating bleakness, or catastrophic danger are missing, it is possible to detect the inability of the patient to regain in the dream some reintegration. As an example of this possibility, Ephron reports the following dream: “I dreamt about the sea all night. I kept waking up. I remember being down by the shore and building castles and having them washed away. And there were erotic dreams, also, because I also was having dreams about having intercourse.” Ephron says that the patient ‘‘seems to attempt to establish a home territory during sleep, to build her own identity by constructing a fantasy castle. But like a little child, she builds her castle only of sand, and it is repeatedly washed away into an ego-less void.”

Ephron goes on to say that although the patient reaches eventually for orientation in another direction—sexual contact—she does so in a strange depersonalized intimacy. The dreamer does not have intercourse with any specific person. In the dream there is only a vague sense of sexuality occurring in a void.

As a result of my work with many patients treated with prolonged psychotherapy, I can draw the rule-of-thumb conclusion that schizophrenics and nonschizophrenics differ much less in their dreams than in their waking life. This basic finding is easy to explain: in fact, the dreams of every human being are characterized by the supremacy of the primary process. However, if we examine a large number of dreams of schizophrenics, we recognize the following characteristics more frequently than in dreams of other people:

1. The element of bizarreness is more pronounced. More frequently than in dreams of other people there are transformations of persons into animals, plants, flowers, and so forth.

2. Secondary process material hides less the latent content. Thus in spite of their bizarreness, these dreams are easier to interpret than those of neurotics.

3. There is a pervading feeling of despair or a crescendo of anxiety with no resolution.

These characteristics may persist even when the patient is improving or recovering. However, as we shall describe shortly, when the patient is recovering, other types of dreams are likely to occur.

The following dream offers an example of bizarreness. “I dreamt I was a bee. A bubble of honey connected me to the queen bee so that I could suck the honey. A nasty bee came along and said to me, ‘Go on your own; don’t suck the queen’s honey.’ ” The patient had been sick for many years. At the time she had this dream, she was much better and free of overt symptoms. Her previous therapist, whom she idealized as a deity or a king, and with whom she wanted to retain a symbiotic relation, had moved to another city a few months ago, and she had continued treatment with me. Many sessions had been devoted to discussing her transference with the previous therapist, for whom she had a deep feeling of subservient respect, and on whom she depended “for succor.” A great deal of time was used to discuss how she could break her attachment and become less dependent on any therapist. The patient interpreted her dream by herself. She said that the queen bee was her previous therapist, Dr. X.; and that I was the

nasty bee.

The dream also illustrates the second characteristic: simplicity, easy translation into language of waking life. Other examples of simple dreams will be given in Chapter 40 in relation to the case of Geraldine.

A dream of Robert, a 21-year-old male student, offers an example of the third characteristic:

> I have a horse and a dog. They both run away. I steal a car to look for the dog and horse. The car catches on fire, and I run to the nearest house to call the fire department. I find out that the house is a whorehouse. There are dogs in the whorehouse that seem to act like whore-owned dogs. In the house I see a friend of my sister, and I feel funny for being here. Then I remember shaking hands with somebody and get stung through the hand. It's like a man-of-war stinging feeling."

The patient had recovered from the acute manifestations of a paranoid episode, during which he had many grandiose delusions, one of them consisting of the belief that he was Jesus Christ. When the patient had this dream, he was no longer delusional but had to contend with two major problems: fear of the world and extremely low self-esteem. His outlook on life was very pessimistic. Rather than

reference to specific events, the dream required explanations connected with these two basic feelings.

Many dreams of schizophrenic patients reveal the patients' pessimistic attitude and lack of successful resources to solve problems. However, I cannot share the deep pessimism that could be inferred from reading the authors who wrote on dreams of schizophrenics.

Schizophrenic dreams seem also to have constructive elements. Let us reexamine the dream of the patient who dreamt she was a bee. The bizarreness (being a bee) and the simplicity pointed to a schizophrenic dream style and structure. However, the patient revealed that she had acquired insight. Although I was seen as a nasty bee, the feeling was that I was right and that she should be less dependent on the previous therapist. As a matter of fact a drastic change in the transference situation took place after the occurrence of this dream. Moreover, her seeing the other bee as nasty was an indication that she tried to prevent the formation of a symbiotic transference with the new therapist.

Robert, the patient whose pessimistic dream we have examined,

continued to have dreams with schizophrenic elements, even when the manifest psychotic symptomatology had disappeared. However, these dreams demonstrated a progressive ability to solve the major situations of life. Five months after the dream reported above he had the following one: “The whole world knows that Hitler is alive again, Hitler being me. I feel like writing a book which would prove I am not against the Jews. I want the people of the world to respect, not condemn, me.” Here the patient, who, when he was delusional, identified with the person he thought was the best (Jesus Christ), in this dream is identifying himself with the worst person he could think of (Hitler). But he really does not accept this horrid image of himself. He wants to demonstrate that he is not what people think Hitler was. Robert is not what he believed people thought of Robert. By writing a book he will show his worth.

Four months later Robert had the following dream: “My father is in an accident and he needs a new face. He becomes very sad. I see the face that will be his. It is one of an old man, but when the face is put on, it looks like my next-door neighbor George. The next thing I know is that my father, with the new face, and I are at a high school dance. We both try to dance wildly and have fun like everybody else, but we are

really not having fun dancing."

In my opinion this dream shows improvement and movement toward the solution of the patient's problems. One of his major problems, which played a major role in his psychodynamics, was his relation with his father, with whom he could not identify. Such swinging between unrealistic identifications (Jesus Christ and Hitler) were partially a result of this difficulty. During the postpsychotic period Robert, with the help of psychotherapy, made an attempt to see his father in a different, more realistic way, with "a new face." It turned out that this attempt made father look like his friend George. Father became a peer in whose company he could go to a high school dance. The patient and the father were trying to dance wildly and have fun like everybody else, but they could not. There was thus in the dream a recognition that all the problems had not been solved yet.

Solutions of psychodynamic problems in dreams of schizophrenics are the best prognostic signs. Often these dreams use material very similar to the delusional content that appeared during the acute or active phase of the illness. The similarity of the dream to the content of the psychosis may be evaluated adversely by a therapist

who has little experience with psychotic patients. Actually this is, all in all, a good sign: material that was previously dealt with by the patient in psychotic ways is now dealt with by means of the physiologic psychosis that is available to every human being: the dream. The following is an example. A 23-year-old woman, from a well-to-do conservative Southern family, left her home, where she felt she could not adjust, and came to live in New York City. Soon she started to mingle with a nonconformist group of people living in Greenwich Village. She finally went to live in a common-law marital relationship with an artist, a bohemian type of person, of different religious faith and different family background. One day in 1960, during the United Nations session in which Khrushchev participated, she was caught by the police in an obvious psychotic state, wandering and screaming on the street. She was immediately hospitalized. It was found that she was hallucinating and delusional. She thought that the Russians were chasing her. As a matter of fact, the Russians had invaded the city. New York would be their first base of operation. From there they would attempt to conquer the whole world. Toward sunset, near the Hudson River, she saw the whole sky turning red from the rays of the sun. She interpreted that natural phenomenon as a divine warning that the

whole world would become Red. She had to deliver the message to the people. God had chosen her to save the world.

Later on when the patient got somewhat better it was possible to find out that the episode had been precipitated by a letter received from her parents announcing that they would come for a visit to New York. She became frantic. What would they do if they discovered the kind of life she was living? Now, after having controlled her throughout her youth, they were coming to New York to invade the land where she had found freedom. Her panic intensified and finally changed into a delusional system. Now no longer the parents but the Russians were invading New York.

The patient recovered from the most obvious symptoms in about three weeks, without any physical therapy, with the exception of some sedation when she was hospitalized. A change toward more than superficial improvement, however, was announced approximately a year later by a dream. The patient dreamt that she was being chased by her parents all over New York City. She saw in this dream scenes similar to those she saw in her acute delusional state, including the scene near the Hudson River. She was afraid and kept hiding. Finally,

however, she felt she did not care whether the parents caught her or not. They would not hurt her. She decided she had nothing to hide and went toward the parents to meet them.

Notes

[1] Powdermaker (1952), in her therapeutic efforts, stresses this important point, which was also discussed in this book, especially in connection with catatonics.

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