INTERPRETATION OF SCHIZOPHRENIA

Specific Solutions of Psychotic Mechanisms

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I
Introductory Remarks

Some therapists rely only on the establishment of relatedness in the treatment of schizophrenia, especially in very acute cases. The manifest symptoms disappear at times as soon as relatedness is established. In my experience, although this is true in some cases, in the majority of cases the symptoms persist or return if the patient has not acquired insight into his psychological mechanisms and has not changed his vision of himself, the others, life, and the world. Although psychodynamic interpretations are much better known, interpretations concerning mechanisms and forms are also important, especially at an early phase of treatment. We shall devote most of this chapter to this topic.

Since Jung's formulations, schizophrenic symptoms have been compared to dreams of normal and neurotic persons and have been interpreted similarly. However, whereas dreams are interpreted while

the patient is awake and has reacquired the normal cognitive functions, the schizophrenic has to be treated while he is still in “the dream” of the psychosis.

In this chapter we shall see how with some special technical procedures the patient can be helped to become aware of the ways with which he transforms his psychodynamic conflicts into psychotic symptoms.[1] Although form and content are interrelated, a fundamental distinction remains between interpretations of content given in accordance with more traditional psychodynamic methods and interpretations of forms and mechanisms. Whereas the benefit from traditional interpretations is due, or is believed to be due, to acquisition of insight into repressed experiences and to the accompanying abreaction and therefore is supposed to be immediate, the effectiveness of the second type of interpretation consists of the acquisition of methods with which the patient can work at his problems. They do not consist exclusively of insights passively received, but predominantly of tools with which the patient has to operate actively.

In what follows I am going to discuss this type of treatment with

regard to such symptoms as hallucinations, delusions, ideas of reference, and related manifestations. Before doing so, however, we must clarify some issues.

Insistence on attacking the schizophrenic symptom at any stage of the treatment may appear a restricted and an antiquated procedure. In fact, we have learned not only in psychiatric training but even in medical school that it is not the symptom but the cause of the disease that we should be mostly concerned with. Symptomatic treatment is secondary to causal treatment. This general principle should be followed most of the time. In the most serious psychiatric conditions, however, we find ourselves in unusual circumstances. The symptom is more than a symptom. Often it is a maneuver that tends to make consensual validation impossible and to maintain interpersonal distance. What may have originated as a defense actually makes the whole situation of the patient more precarious and may enhance regression.

Secondly, the symptom stands for a great deal more, actually for what it wants to eliminate but cannot. The symptom is a symbolic barricade around the core of anxiety; it does not permit us to touch the

genuine anxiety. Let us take as an example a typical and common symptom that we have already considered in previous chapters. A patient has an olfactory hallucination; he smells a bad odor emanating from his body. In this symptom a great deal of pathology is encapsulated. The patient feels he has a rotten personality, he stinks as a person. A schizophrenic process of concretization takes place and an olfactory hallucination results. This olfactory hallucination stands for, or summarizes, the whole life history, the whole evaluation of the self, the whole tragedy of the patient. We usually say that the hallucination symbolizes what the patient feels about himself. This is correct, provided we understand that the symbol is a symbol for us, not for the patient. The patient, by virtue of the symptom, stops worrying about his personality and worries only about his stinking body. What we call a symbol actually has a realistic, not a symbolic, value for the patient. It tends to replace the reality that it wants to substitute. The symptom is not, for instance, like a flag that represents a country. The flag is not the equivalent or a duplication of the country it represents. This process of concretization, as exemplified in the hallucination of the patient just mentioned, is perhaps the most common mechanism in schizophrenia and, as we have studied in this book, is related to

altered cognition. Whatever cannot be sustained at an abstract level, because it is too anxiety provoking, is reduced to, or translated into, concrete representations.

At this point an important question may arise in the mind of the reader. If the symptom is a substitution for such a great part not only of the illness but also of the life of the patient, is it not true that the patient needs this substitution? He needs to eliminate so much mental pain, and the therapist, in a cruel and antitherapeutic way, wants to deprive him of his precious defense.

The point is that if an atmosphere of basic trust is developed in which the patient feels he obtains a great deal from the therapist in human relatedness, he is willing to relinquish his symptoms or to experiment with ways that convert them into less psychotic or neurotic ones. The new symptoms, like the recognition of being concerned with one's own personality and not body, may be more difficult to bear but can be more easily shared with the therapist. In other words, the therapist will be able to help the patient to bear "his cross," if this cross is a less autistic or less psychotic one.

Some people may ask, why not remove symptoms with less difficult methods; for instance, with drug therapy? Symptoms can and should be eliminated with drug therapy if psychotherapy fails. However, the patient who is able to conquer his symptoms by psychological means reacquires an active position in his life. He no longer feels victim of persecutors or of phenomena that he does not understand. He becomes more aware of the role he plays in his illness; how at times he can actually choose between the realm of psychosis and the realm of reality; how even in such apparently immutable processes, which he takes for unchangeable reality and which we call hallucinations and delusions, he can recognize that it is up to him to resist the seduction of the abnormal mechanisms. He will be able to accept the increased anxiety and increased suffering coming from nonpsychotic mechanisms and from the knowledge of the meaning of the nonpsychotic processes if he feels that the therapist is there to share that anxiety and that suffering.

In other words, whereas the intangible gift of relatedness is offered freely to the patient and at least in the beginning is received by him passively, the formal interpretations given to him become tools that he actively uses to fight his own illness. He soon recognizes what

he himself does to the world of reality in order to transform it into the world of psychosis. Examination of this transformation by the therapist and the patient is a common exploration, where patient and therapist retain different mutually active roles.

II
Hallucinations

Until recently the opinion prevailed that incorrigibility was one of the fundamental characteristics of hallucinations. That is, until the symptom altogether disappeared, either through treatment or spontaneously, it would be impossible for the schizophrenic patient to become aware of the unreality of the phenomenon and to correct it. I have found that this is not necessarily so (Arieti, 1961b, 1962a). Only auditory hallucinations will be taken into consideration, but the same procedure could be applied to other types of hallucinations, after the proper modifications have been made.

Hospitalized patients approached with old, routine questions such as “Do you hear voices? Who is talking to you?” are unable to give up their hallucinations. As long as an atmosphere of unrelatedness exists, the patient cannot make an effort to see and hear things as

other people do, and it is unwise to attack the problem directly. However, it is also unwise to give the patient the impression that the therapist hears his voices and shares his unusual private experiences. The therapist should simply tell the patient that he does not hear the voices and will maintain an attitude of cordiality and relatedness.

With the exception of patients who are at a very advanced state of the illness or with whom no relatedness can be reached, it is possible to recognize that the hallucinatory voices occur only in particular situations, that is, *when the patient expects to hear them.*

For instance, a patient goes home after a day of work and expects the neighbors to talk about him. As soon as he expects to hear them, he hears them. In other words, he puts himself in what I have called *the listening attitude.*

If we have been able to establish not only contact but relatedness with the patient, he will be able under our direction to distinguish two stages: that of the listening attitude and that of the hallucinatory experience. At first he may protest vigorously and deny the existence of the two stages, but later he may make a little concession. He will say,

“I happened to think that they would talk, and I proved to be right. They were really talking.”

A few sessions later, however, another step forward will be made. The patient will be able to recognize and to admit that there was a brief interval between the expectation of the voices and the voices. He will still insist that this sequence is purely coincidental, but eventually he will see a connection between his putting himself into the listening attitude and his actually hearing. Then he will recognize that he puts himself into this attitude when he is in a particular situation or in a particular mood, for instance, in a mood on account of which he perceives hostility, almost in the air. He has the feeling that everybody has a disparaging attitude toward him, and then he finds corroboration for this attitude of the others; he hears them making unpleasant remarks about him. At times he feels inadequate and worthless, but he does not sustain this feeling for more than a fraction of a second. The self-condemnation almost automatically induces him to put himself into the listening attitude, and then he hears other people condemning him.

When the patient is able to recognize the relation between the

mood and putting himself in the listening attitude, a great step has been accomplished. He will not see himself any longer as a passive agent but as somebody who still has a great deal to do with what he experiences. Moreover if he catches himself in the listening attitude, he has not yet descended to or is not yet using abnormal or paleologic ways of thinking from which it will be difficult to escape. He is still in the process of falling into the seductive trap of the world of psychosis but may still resist the seduction.

That he is not just a passive agent, he may find out from an opposite procedure. The patient who is prone to hallucinate is told to go into another room alone and to expect to hallucinate. Soon he will realize that the voices come, just because he expected them.

I have found that if an atmosphere of relatedness and understanding has been established, patients learn with not too much difficulty to catch themselves in the act of putting themselves into the listening attitude at the least disturbances, several times during the day. At times, although they recognize the phenomenon, they feel that it is almost an automatic mechanism, which they cannot prevent. Eventually, however, they will be able to control it more and more.

Even then, however, there will be a tendency to resort again to the listening attitude and to the hallucinatory experiences in situations of stress. The therapist should never tire of explaining the mechanism to the patient again and again, even when such explanation seems redundant. It is seldom redundant, because the symptoms may reacquire an almost irresistible attraction.

But now that we have deprived the patient of his hallucinations, again you can ask, how will he be able to manage with his anxiety? How can we help him to bear his burden or a heavier but less unrealistic cross? An example will perhaps clarify this matter. A woman used to hear a hallucinatory voice calling her a prostitute. Now, with the method I have described, we have deprived her of this hallucination. Nevertheless she experiences a feeling, almost an abstract feeling coming from the external environment, of being discriminated against, of being considered inferior, of being looked upon as a bad woman, and so forth. She has almost the wish to crystallize or concretize again this feeling into a hallucination. If we leave her alone, she will hallucinate again. If we tell her that she projects into the environment her own feelings about herself, she may become infuriated. She says, “The voices I used to hear were telling me

I am a bad woman, a prostitute, but I never had such a feeling about myself. I am a good woman." The patient of course is right, because when she hears a disparaging voice, or when she is experiencing the vague feeling of being disparaged, no longer has she a disparaging opinion of herself. The projective mechanism saves her from self-disparagement. We must instead point out to the patient that there was one time when she had a bad opinion of herself. Even then she did not think she was a prostitute but had a low self-esteem, such as she probably thought a prostitute would have about herself.

In other words, we must try to reenlarge the patient's psychotemporal field. As long as he attributes everything to the present, he cannot escape from the symptoms. Whereas the world of psychosis has only one temporal dimension—the present—the world of reality has three: past, present, and future. Although at this point in the illness the patient already tends to live exclusively in the present, he retains a conception of the past, and such conception must be exploited. We direct the patient to face longitudinally his deep feeling of inadequacy. At the same time the therapist with his general attitude and firm reassurance and sincere interest will be able to share the burden. At this point the therapeutic assistant may be very useful, as

we shall discuss later.

The realization of the low self-esteem is not yet a complete psychodynamic explanation of the symptom, but at this stage of the treatment we stop at this explanation. The matter will be pursued later, when we shall examine factors in the early family environment that led to this negative self-appraisal. We have seen, however, that any formal mechanism that is pursued to its origin discloses not purely the nature of its form but its psychodynamic counterpart. This multifaceted nature of the symptom is seen even more clearly in other psychotic phenomena that can be called at the same time hallucinatory, illusional, delusional, or referential. For instance, a patient has the idea that people laugh at him. He actually hears them laughing, and he turns his head; he looks at them and sees them smiling and ridiculing him. They may not smile at all, and he may misinterpret their facial expression. If they do smile, they may do so for reasons that have nothing to do with him. Again we must help the patient to recognize that he sees or hears people laughing at him when he expects to see or hear them. However, when the treatment is more advanced, the patient recognizes that he feels people *should* laugh at him because he is a laughable individual. He hears them laughing

because he believes that they should laugh at him. What he thinks of himself becomes the cause of his symptoms. It is painful for the patient to acknowledge that that is what he thinks of himself. In this case also, the psychotic mechanism will dissolve itself when it is understood both formally and psychodynamically and when the patient, with the help of the therapist, is able to bear the unpleasant psychodynamic meaning.

Another patient cannot look into the eyes of some people because those eyes send telepathic messages with unpleasant content. The patient sees and hears the messages. He must realize that he expects to be made uncomfortable by those people, by those eyes that scrutinize and criticize, and must learn eventually from the events of his past history why he has attributed to these people the power to make him uncomfortable. Moreover, "being uncomfortable" is transformed or perceived by him as being persecuted or being the victim of telepathy. In most instances, after the symptoms have been understood formally and the patient is able to control or check them, they will be understood psychodynamically as related to the patient's self-image and to the projective mechanisms by which the patient tried to hide his self-image.

III
Ideas of Reference, Delusions, and Projective Mechanisms

What we have said about hallucinations could with the proper modifications be repeated for ideas of reference and delusions. Before the delusions or ideas of reference are well formulated, the patient must learn to recognize that he is in what I call the referential attitude. For instance, he is taking a stroll in the park on a beautiful Sunday afternoon when all of a sudden peculiar events begin to take place. People sitting on the benches start to talk with animation and to look at him with strange eyes. They make some gestures that have obvious reference to him. Children who were running all over or playing in the nearby playground now all run toward the opposite direction to avoid being near him. An American flag that could be seen from the distance, open to the wind and waving on the top of a pole, is now drooping. All this is an indication that people think that a horrible man, perhaps a pervert who attacks children and women, is in the park. The patient is supposed to be that man. The news is spreading. He rushes back home in a state of intense, agonizing turmoil.

And yet, we must ask him when he comes for the session, what happened before he went into the park? In what mood was he? Was he

not looking for a certain evidence? Did he not almost hope to find it, so that he would be able to explain that indefinite mood of being thought of as a horrible creature? He had the impelling need to transform a vague, huge menace into a concrete threat, to restrict to a specific event a spreading feeling of being humiliated, disparaged, discriminated against (Chapter 16).

The direct attack on the symptom consists again in making the patient aware of his concretizing the vague threat. He must recognize how he substitutes ideas and feelings for others that are easier to grasp or to contend with in his distress. He will learn to check himself, as he may learn to check his listening attitude.

But again we made him retranslate the concrete into the abstract and reintroject what he had projected. Will he be able to do so? He will, if we share his burden with the ultimate aim of removing it altogether. The patient must become aware that he is searching for references that will corroborate the preexisting mood. Let us take another example, that of a patient who tells us that while he was in the subway he observed peculiar faces, some unusual motions that some people made, an unusual crowd at a certain station, and how all this is

part of a plot to kidnap him and to kill him. It is useless to reply to him that these are imaginary or false interpretations of certain occurrences. At this point he is forced to believe that these events refer to him. We must instead help the patient to recapture the mood and attitude that he had prior to those experiences, that is, we must help him to become aware of his *referential attitude.* He will be able to remember that before he went into the subway, he looked for the evidence, he almost hoped to find it because if he found that evidence, he would be able to explain the indefinite mood of being threatened that he was experiencing. He had the impelling need to transform a vague, huge menace into a concrete threat. The vague menace is the anxiety of the interpersonal world, which in one way or another constantly reaffirms the failure of his life.

The patient is then made aware of his tendency to concretize the vague threat. The feelings of hostility and inadequacy that he experienced before the onset of the psychosis have become concretized, not to the point of becoming hallucinations, but to the point of delusions or of ideas of reference. No longer does the patient feel surrounded by an abstract worldwide hostility. It is no longer the whole world that considers him a failure; now “they” are against him,

"they" call him a failure, a homosexual, a spy. This concretization is gradual. The "they" obviously refers to some human beings who are not better defined (see Chapter 8). We make the patient aware not only of his referential and delusional attitude, but also of his *concretizing attitude* (see Chapters 15 and 16). The symbolism is often clearly understood if the patient, supported by our sharing of his anxiety and pain, is able to accept the impact of the revelation. For instance, a patient may be helped to recognize that it is easier for him to think that his wife poisons his food than to think that she "poisons" his life. He may also recognize that the feeling he has that some people control his thoughts is a reactivation and concretization of the way he once felt that his parents were controlling or trying to direct his life and his way of thinking. If relatedness is achieved, the patient becomes gradually aware of the almost incessant process of transforming the abstract part of his life into concrete representations.

Some of this active concretizing may be difficult for some patients to understand, especially in some manifestations. However, a large number of patients will eventually understand it with great benefit. One of the most apparently obscure and yet most important manifestations of this process of concretization is a phenomenon that

has baffled not only patients but psychiatrists as well. A patient happens to think, let us say, that dead relatives are coming to visit him in the hospital. As soon as such a thought occurs, the thought becomes a reality! He believes that the relatives are already there in the hospital. Thoughts are immediately translated into the real facts that they represent, just as in hallucinations and in dreams they are transformed into perceptions. A thought that represents a *possibility* cannot be sustained. Schizophrenics are still capable of conceiving and even sustaining thoughts of possibilities, when they do not involve their complexes. However, possibilities concerning anxiety-provoking situations are conceived by the schizophrenic but not sustained for a long time: they are translated into actuality.

The patient is made aware of this tendency, and although at the beginning of the treatment he may not be able to arrest the process, he becomes familiar with what he himself is doing to bring about the delusional world.

In some other instances, it is through the content of the symptom that we can help the patient to recognize the concretizing attitude. A patient in her middle twenties had the delusion that she was receiving

messages from a power higher than herself that were directing her life. The pulsations, of which she was aware when she was pressing her wrists, were like a Morse code that would tell her what to do or not to do. These messages were pearls of wisdom that told her which situations would endanger her life or put her in awkward positions. Because of the feeling of relatedness that already existed, it was relatively easy to explain to the patient that these commands were actually advice she gave herself. However, she would not accept them as long as they came from her. She had to believe that some important and benevolent external authority or power was sanctioning her decisions. Related to this belief was her complaint that her parents had never been able to guide her or to let her grow as an independent person.

Some patients present some symptoms that are halfway between delusions and phobias. The fears that they express are generally concrete representations of what they experience in a more abstract way. A patient says that he is afraid of certain people, and he does not know why. There is nothing in these people that should make him afraid. We must help the patient realize that these people, whom he believes he is afraid of, make him feel uncomfortable. They indeed

have the power to make him uncomfortable, but he transforms or concretizes the psychological discomfort into fear. If the patient acknowledges the discomfort caused by the presence of these people, he moves much closer to reality. Of course, the inquiry should not stop here. Eventually we must determine why such people have the power to make him uncomfortable. What are the connections with the patient's past history or what are his symbolic associations?

Other patients are afraid of big crowds. The big crowd represents "the pulsating life," and the patients are afraid of life or of being defeated in life. Other patients may be afraid to go into buses or streetcars because they feel exposed. "People will find out what I am like." All these fears are obviously connected to the negative self-image. In psychotherapy the projective mechanism has to be dismantled, but the more we succeed in doing so, the more the patient has to become painfully aware of his adverse vision of himself.

The concretizing attitude is expressed not only by ideas and delusions but also by bizarre behavior. We shall use here again some examples already considered in Chapter 17. Some patients always stand close to a wall, away from the center of the room. The habit is so

common and so well known that we are not liable to make mistakes if we say to the patient, “You want the wall to protect you from the threatening feelings you sense all around. I am here with you. Nothing will attack us. Nothing will injure us. We need no walls. Let’s walk together.”

To some patients who injure themselves to substitute a physical pain for an emotional one, we may say, “You want to hurt yourself to remove your anguish. If we talk about it, we share the pain; the pain will decrease.” This explanation has to be given with some cautiousness because self-injury is not always an attempted concretization of mental pain or a way to make the pain “more real.” At other times it is exclusively or predominantly an expression of need for punishment or a way to achieve change in gender or to inflict bodily disfigurations that have a symbolic meaning.

A frequent symptom is screaming; at times a loud, terrifying scream occurs abruptly. Screaming is a way of expressing sorrow, powerlessness, and protest in a more primitive way than even the crying of the sufferer. Crying, as a baby would do, has an appealing quality, which the scream does not possess. The patient feels he

cannot appeal to anybody. His lifelong whimpering was never heard, and he must scream now. But the therapist must perceive the scream as a dramatic revolt against the lifetime suffering in quiet and desolate solitude. He must let the patient know that he has received the message and is ready to answer it.

Different, although related, is the apparently inappropriate hebephrenic smile or, less frequently, the almost spasmodic laughter. The patient laughs at it all, or laughs the world off. The trouble is too big, too lurid; not only must you keep distance and have nothing to do with it, you must actually laugh at it. The therapist must receive the hebephrenic's message of defiance and rejection of the world and help him to find at least a little part of this big world at which he does not need to laugh.

Fromm-Reichmann reported a female schizophrenic patient who always walked with a thumb extended and the other fingers flexed over the palm of her hand. Fromm-Reichmann did not interpret the extended thumb as a phallic symbol or as indication of penis envy. For her it meant "I am one: alone, alone, alone!" (reported in Arieti, 1968c).

This concrete way by which attitudes and feelings are experienced and expressed in behavioral forms has been compared by some to surrealistic art (Barison, 1948; Roi, 1953). But surrealism can be shared and appreciated and used as a partial return to realism or as an extension of reality.

IV
Awareness of the Punctiform Insight

In some delusions and ideas of reference there is an element of reality that is valid at a realistic level as well as at a symbolic level. The coincidence between psychosis and reality is exploited to make contact with the patient and to develop consensual validation in some areas. Freud (1937) also postulated that in delusions and hallucinations there is a fragment of historical truth and hoped that one day the liberation of this fragment would lead to useful therapy. In some cases of relatively mild forms of psychosis I have been able to follow Freud's suggestion, with some modifications. The fragment of truth did not refer to the past life but to the present. Moreover, the concrete event, of which the fragment of truth consisted, could be accepted both at a realistic face value and as a symbol.

When what seemed delusional is recognized as real insight, not only is the patient praised for the insight but helped to see that the insight has a larger scope because it includes not only the realistic episode but its symbolic meaning. An example will illustrate what I mean. Violet, a 35-year-old single patient, was suffering from a relatively mild form of schizophrenia that permitted her to maintain a not too inadequate social life and to keep her job in spite of her many symptoms. She had occasional hallucinations, some delusions, and numerous ideas of reference.

On her birthday she received a bouquet of roses from the company for which she worked. When she opened the package and saw beatuful yellow roses, instead of experiencing a happy feeling, she started to concentrate on the color yellow. The color is supposed to mean jealousy, and she felt that by giving her yellow roses the people in the office wanted to let her know that they knew she was jealous of the wife of the boss. The following day she heard one of the workers humming the song "The Yellow Rose of Texas," and she felt this was done purposefully to expose her.

Eventually everything that was yellow in color acquired the same

meaning for her and had to be avoided. Finally she even got rid of two of her dresses, because they were yellow.

In her office there was a water cooler that was out of order and that had to be hit in order to let the water flow. When people, and especially the boss of her department, were hitting the cooler, she thought they meant to hit her. When I asked her why she thought so, she said, "I never walk. I run, like water, and I deserve to be hit!" I explained to her that when she was in a state of anxiety, she resorted to a special type of thinking to demonstrate her unworthiness, and that she attributed to others the feelings she had about herself. This explanation helped, and for some time there was considerable improvement, but then similar symptoms came back. For instance, when people in the office and especially the boss in the department were using the word *machine,* she was sure they were referring to her. She said, "I work like a machine. I am sure they refer to me."

One day Violet came to my office in an angry mood and told me that she was angry because the previous day her friend Lucy had come to visit her and had brought along her dog, a little cocker spaniel. She added, "You see! She thinks my home is a doghouse. She thinks I am a

dog."

Occasionally I use some examples taken from one patient in my explanations to other patients with whom I have established relatedness, in order to make them aware of the mechanisms they are liable to use when they are in distress. It happened that I reported this episode of the dog to another very articulate and sensitive schizophrenic patient, who told me, "Your patient is probably right. Her friend probably treats her as a dog. Do you know that dog-owners own dogs because they want to treat people like dogs? A human being does not obey them easily, but a dog does. I keep away from people who own dogs."

Of course I did not accept my patient's point of view that dog-owners necessarily have those characteristics, but I remembered that a small percentage of dog-owners whom I have treated, do own dogs for the reasons mentioned by my patient. It occurred to me also that Lucy, Violet's friend, fitted that description very well. She was a domineering, aggressive person who was treating people like dogs, especially masochistic and compliant persons like my patient, who were willing to accept her behavior unconditionally. I realized then

that Violet had had good insight in thinking that Lucy was treating her like a dog, but this insight was sustained not by logical thinking or convincing evidence, but by the evidence brought forth by a small, otherwise insignificant episode. I reexamined all the bizarre symptoms Violet had experienced and discussed them with her. The chief of the department who was hitting the water cooler in a forceful manner was then recognized as a hostile and demanding person who gave Violet a tremendous amount of work and showed hostility at the least provocation, taking advantage of her submissive and masochistic characteristics. It is probable that by hitting the cooler after talking to her, he was letting off hostility. Perhaps he was doing something emotionally equivalent to a desire to hit Violet when she dared not comply in an absolute manner. Most probably my patient had intuitively recognized in this apparently harmless act of the boss a gesture of displaced hostility. My patient thus had insight, but the insight was sustained by paleologic thinking and concretization. She was more intuitive than the average person in recognizing this gesture of the boss as an act of hostility directed toward her, but for her the act had become equivalent to an overt act of hostility. For the normal person, the act is not equivalent to an act of hostility but is only

symbolic: at the level of reality hitting the cooler is different from hitting Violet. Continuing in her paleologic thinking, the patient then extended to all members of the firm the intention intuitively perceived in the boss.

The patient also had the conviction that when her co-workers used the word *machine,* they were referring to her. In fact, they actually were treating her as a machine, not as a person, by taking advantage of her efficiency and willingness to do a large amount of work without protest, like a machine. There is no doubt that people working in the firm had realized that her excessive work and compliance were due to some kind of abnormality in her personality, but nevertheless they took advantage of her condition. The bouquet of roses, or similar gestures, were thus acts of compensation for exploiting her, but at the same time an acknowledgement that there was something unusual with her, symbolized by her being jealous of the boss's wife.

A reconsideration of Violet's symptoms disclosed that in her ideas of reference there was always some truth—I would say at least a grain of truth. This grain of insight, however, remained a grain, a

punctiform insight, and did not expand into a complete insight, for the following reasons:

1. It could not transcend the level of immediate reality that made the insight possible. Although the insight was obviously derived from a more general or abstract evaluation of the total situation, this total evaluation had become unconscious, and the patient was aware only of the significance of the concrete event, which was accepted as expression of reality, not as a symbol. Thus Violet felt hit only as the cooler was, literally treated as a dog, and so forth.

2. The patient tried to attune or accord with the symptom the rest of her life, but attempts of this kind remain incongruous with reality. In other words, instead of enlarging the insight to an abstract level, the patient generalizes it at a concrete level, actually distorting the rest of reality to fit the concreteness of the manifestation.

This partial insight can be used psychotherapeutically. The patient must be told that he has insight, that he saw some truth. When we reexamined the symptoms, I told Violet that she had unusual understanding in perceiving that the boss wanted to hit her and in realizing that Lucy was treating her like a dog, and I praised her for

such understanding.

This is, of course, interpretation, but from a new slant. The interpretations we generally give the patient concern their inner reality; here it is suggested instead that we tell him how the inner reality coincides with his appreciation of the external world, and how accurate this appreciation is at times. The insight is not given as something that the patient will passively accept, but as something he has actively created. As in the case of the recognition of the listening attitude, the patient changes from a passive to an active role. In other words, we use the little gaps of reality in the realm of the psychosis, or, to put it in a way that I prefer, we use the points of agreement between psychosis and reality.

The benefit the patient receives from this method is not just the result of some kind of intellectual agreement between two debating persons, which will help therapist and patient to move toward large areas of consensus and shared experience. Violet felt much better and no longer alone with her strange symptoms. She felt I shared her feelings and ideas. I did not pretend to do so. Since then Violet started to improve; she became more socially adequate and was able to

sustain relations with men. At the age of 39 she got married, and at the age of 40 she had a child.[2]

The method of acquiring awareness of the punctiform insight may present risks if not applied appropriately. For instance, if the patient accepts the insight only at the level of concretization, he may act out in accordance with his psychosis. The therapist must intensively help him move away from the point where psychosis and reality converge. This is possible in an atmosphere of relatedness and under the momentum generated by the conviction that some points of view are shared with the therapist.

For instance, Violet was told that it was true she was treated as a machine and what a sensitivity she had in realizing that they treated her as if she were a machine. But what could she do to change the situation? How could she change her attitude, so that she would no longer be treated as a machine?

The method of acquiring punctiform insight has unfortunately serious limitations, inasmuch as it can be applied only to a certain number of patients who present a mild form of psychosis. In this group

of patients, the symptomatology is actually promoted by the reality situation, and its connections with reality are relatively easily found. In most other patients, ideas of reference, tendency toward meanings, discovering puns, and so on, have no connection with the reality shared with other people, but only with the associations of the patient's inner reality.

V
Awareness of Abnormal Cognition

Throughout this book we have seen how important is the study of abnormal cognition for the understanding of the nature of schizophrenia in general as well as of the specific symptomatology. It also permits an evaluation of the state either of regression or reintegration of the patient. It permits the therapist to understand the way the patient thinks and talks, even when at first it seems impossible to do so.

In therapy, however, a knowledge of the abnormal cognition of the schizophrenic may also be more directly useful, because it enables us to explain to the patient his faulty patterns of thinking. Actually all inteipretations that we have discussed in this chapter are based on the

study of abnormal cognition. At a later stage of treatment the patient may become aware of the fact that some of his interpretations are based on a special form of thinking (paleologic thinking).

The therapist must be able to recognize this form of thinking and logic and explain it to the patient. It is beyond the puipose of this chapter to repeat the characteristics of schizophrenic cognition.

If the patient is very regressed, he will not benefit from any direct explanation from the therapist. The therapist will benefit indirectly, however, because his knowledge of the formal characteristics and ways of thinking will enable him to understand the degree of regression and the hidden meaning.

There are, however, some ways of thinking used by the schizophrenic that are not too dissimilar from those used by normal persons, and these can be better explained to the patient. One of them is rationalization, which we discussed in Chapter 16. In the examples given there we saw that there is an important difference between the rationalization of normal people and the absurd rationalizations of the schizophrenic. The reader is referred to that chapter again so that he

can apply to therapy the understanding of schizophrenic rationalization. In rationalizations of schizophrenics there is no congruence or concordance between the external facts, used as excuses, and the psychodynamic meanings and needs. The rationalizations become plausible only if we understand what is suppressed, substituted, or concretized, if we know the complicated experiences the patient went through. It is only when the patient is told what he is doing and when we share with him the anxiety of the knowledge of what was once repressed that he will be less likely to resort to implausible rationalizations.

Notes

[1] For the content of this chapter I have drawn liberally from my previous writings on this subject (Arieti, 1955, 1961b, 1962a, 1963a, 1965a).

[2] At the time of this writing the child is 7 years old. The whole family is well and happy.

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