INTERPRETATION OF SCHIZOPHRENIA

Study of Paranoid Patients

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The paranoid type of schizophrenia presents many aspects for clinical exploration and study. The rich variety of its manifestations and the complexity of its psychodynamic patterns will be the object of various parts of this book.

In Chapter 8 we have already studied the formation of delusions at the onset of the psychosis. As an introduction to the psychodynamic analysis of paranoid schizophrenia a relatively simple case will be presented in this chapter. Then some comments will be made on this case and on paranoid patients in general. More difficult cases, presenting new dimensions, will be studied in Part Seven in relation to psychotherapy. The structure of paranoid mechanisms will be discussed in detail in Parts Three and Four.

Laura

Laura was a 40-year-old married woman. A few weeks prior to her first examination, her husband had noted restlessness and agitation, which he interpreted as being due to some physical disorder.

A physician who was consulted prescribed a tonic. Later Laura started to complain about the neighbors. A woman who lived on the floor beneath them was knocking on the wall to irritate her. According to the husband, this woman had really knocked on the wall a few times; he had heard the noises. However, Laura became more and more concerned about it. She would wake up in the middle of the night under the impression that she was hearing noises from the apartment downstairs. She would become upset and angry at the neighbors. Once she was awake, she could not sleep for the rest of the night. The husband would vainly try to calm her. Later she became more disturbed. She started to feel that the neighbors were now recording everything she said; maybe they had hidden wires in the apartment. She started to feel "funny" sensations. There were many strange things happening, which she did not know how to explain; people were looking at her in a funny way in the street; in the butcher shop, the butcher had purposely served her last, although she was in the middle of the line. During the next few days she felt that people were planning to harm either her or her husband. In the neighborhood she saw a German woman whom she had not seen for several years. Now the woman had suddenly reappeared, probably to testify that the patient

and her husband were involved in some sort of crime.

Laura was distressed and agitated. She felt unjustly accused, because she had committed no crime. Maybe these people were really not after her, but after her husband. In the evening when she looked at television, it became obvious to her that the programs referred to her life. Often the people on the programs were just repeating what she had thought. They were stealing her ideas. She wanted to go to the police and report them. At this point the husband felt that the patient could not be left alone, and after a brief telephone conversation with the family doctor, a consultation with me was arranged.

When I saw Laura, she repeated all her allegations to me. She was confused, agitated, and afraid. Everything seemed to have a hidden meaning, but she did not know how to put all these meanings together. She was very distressed and unwilling to explain. If the husband or someone else doubted the validity of her beliefs, she would become infuriated.

Laura was hospitalized the same day. In the hospital several attempts were made by the members of the staff to treat her

psychotherapeutically, but to no avail. As a matter of fact, it seemed that every such attempt made her worse. The patient was in a state in which every interpersonal approach would increase her anxiety to an enormous degree and would promote the development of defensive paranoid symptomatology. For instance, she manifested paranoid attitudes toward every nurse who took care of her. Inasmuch as a non-anxiety-producing interpersonal relationship could not be established, the staff agreed to treat her with electric shock therapy.[1] She received four electric shock treatments, during the last of which she sustained a minor fracture of a lumbar vertebra. It was felt, then, that insulin therapy should be instituted. After fifteen comas, the patient seemed to be free of overt symptoms, was discharged from the hospital, and came to my office for treatment, as previously agreed. At this point she was no longer afraid of contacts. On the contrary, she was eager to come for treatment, although she was a little resentful about telling her past. She realized that she had had a nervous breakdown and attributed it to her present difficulties with her husband. In the course of the treatment she was able to give an adequate account of her past history.

Laura was born in Vienna, Austria, of Jewish parents. Her father, a

painter, died while fighting in World War I. She did not remember him, but from a picture her grandmother had once shown her, she knew that he was a handsome man. Her mother remarried soon, even before the end of the war, and went to live with her second husband in a small town in Germany. The early period in the life of the patient is somewhat confused. She saw her youth, from as early in her childhood as she can remember to her late teens, as a sequence of changes of residence back and forth from Germany, where her mother lived, to Austria, where her maternal grandparents were. It was not absolutely clear to the patient, in the beginning of treatment, why she had had to move so many times, perhaps once every six months. She remembered later, however, that she was not happy living with her mother. Her mother was interested in her own personal affairs, but not in the child. Laura remembered her stressing the fact that she was sending her daughter to the best nursery schools and other schools since she was very little. Later the patient came to realize that this was a device her mother used not to have her around. Laura's mother was not very affectionate, and yet always blamed the patient for not being affectionate toward her. She used to say, "I buy you clothes, toys, and still you give me no affection." Still, when Laura would try to kiss her

mother and sit on her lap, her mother would say, “Don’t be silly.” Her mother’s attitude was so inconsistent that Laura did not know what to do. Most of the time, however, she preferred not to show any signs of affection because she was afraid that her mother would think she was not sincere. Thus, she gave the impression of being cold and distant.

Her mother would also accuse her of lying. The patient did not remember what specific lies her mother accused her of, but she did remember that she was accused several times. Laura remembered her disagreeable voice saying, “This child is lying.” She felt unjustly accused and was very unhappy. She was very obedient, but she obeyed only in order not to be accused, not because she felt that her mother’s instructions were right. She often expected to be accused. Whenever she was accused, she felt guilty, even if she had not done anything. At the same time, she had a feeling of repulsion for her mother.

Laura liked to have pets. Once she had a dog, and another time guinea pigs. On one of her returns from Vienna, she found out that the dog had died. She became very depressed about it, asked her mother about the death of her dog, and was given many contradictory explanations. Her mother told her once that the dog had had a heart

condition and had died of a heart attack; another time, that he had run away; still another time, that the animal had contracted a terrible disease and had to be destroyed. According to Laura, her mother forgot each time what she had told her before about the dog. The result was that she knew that her mother had ordered the dog destroyed, against Laura's wishes.

The guinea pigs also disappeared one day, and the mother said that they had just died of a "sunstroke." Laura felt that her mother had ordered them killed because it was too much trouble to have them in the house.

Her stepfather, according to Laura, was a nice man, but he was disinterested in her. Her mother, also, was much more interested in him than in the child. Every time she was in Germany, Laura felt unhappy; she wanted to go to live in Austria with her grandparents. Sometimes she even threatened suicide if she were not sent to Vienna. When she was in Vienna, she would feel better, but she was not happy there either. Her grandmother was relatively tolerant, but her grandfather would often say, "This is not your home. Children must stay with their mothers." When she was sent back to Germany, the

same cycle would begin again. Moreover, the German children considered her a foreigner, a stranger, and she felt alone.

Laura's desire was to become independent and leave home as soon as possible. Throughout her childhood she attended dancing schools, and she became a professional dancer at the age of 20. In the meantime, her mother and stepfather moved to South America, and soon they stopped corresponding with her. Laura did not know whether they were still alive. Her grandparents died, and she continued her theatrical career. She was very successful and was booked for vaudeville theaters in many European countries, but she performed mostly in Germany. Her occasional encounters with men were not too important.

It was during one of her tours in Germany that Laura met her husband. He was a French tourist, a businessman, who became interested in her acting. He would often go to Germany from France just to see her. He overwhelmed her with his consideration and interest, and Laura felt that she liked his attention. She had some qualms about leaving her theatrical career and marrying him, but finally she decided to do so. They were married and went to live in a

small provincial town in France where the husband's business was. Laura felt like a stranger immediately; she was in an environment very different from her own and was not accepted by his family. There were realistic grounds for her feelings. They considered her a foreigner and could not forgive her for having been a dancer, and not a "regular girl." She spent a year in that town and was very unhappy. She felt that when there were arguments or controversies, her husband always took the side of his family and never took her part.

Finally, because of the uncertain political situation in Europe, Laura and her husband decided to immigrate to the United States, along with her husband's sister. Laura did not get along well with her sister-in-law and again felt that her husband showed favoritism toward his sister.

The years spent in America had not been easy ones. Laura and her husband had not been happy together. They had different points of view about many things, and the gap caused by their different backgrounds was never closed. Laura's husband became more and more intolerant of her attitude and started to neglect her. Nothing would irritate her more than his lavish attentions to his sister. They

had no children, and Laura again showed interest in pets. She had a dog to whom she was very devoted. The dog became sick and partially paralyzed, and veterinarians felt that there was no hope of recovery. The dog required difficult care, and her husband, who knew how she felt about the animal, tolerated the situation for several weeks. But finally he broached the problem to his wife, asking her, "Should the dog be destroyed or not?" From that time on Laura became restless, agitated, and depressed. As we know, her symptoms became progressively worse until the time of her hospitalization.

This case is not too difficult to understand. The childhood of this patient was bad enough to produce excessive anxiety, and to give her the feeling that she was not wanted and not loved. It is interesting that although Laura's mother was unwilling to give her care and affection, she blamed the child for not loving her. The patient felt guilty, probably on account of the hostility she had toward her mother. She felt that when her mother accused her of lying, she referred to her hostile thoughts rather than to her actions. Actually the mother was the one who lied. The example of the dog indicates that Laura had realistic reasons for becoming suspicious and anticipating hostility from the surrounding adults. At the same time, the mother was

suspicious of her. Laura was not criticized for her actions, as people who become catatonics generally are, but for her intentions. She had to defend herself by anticipating these false accusations. At times she would deny them; at other times she would accept them because her guilt about her own feelings of hostility did not allow her to reject them.

Laura's suspicious personality was determined by the actions of her mother, whose inconsistencies provoked uncertainty and anxiety in her. She was very badly disappointed by her mother; she trusted her, and her trust proved to be unfounded. There is enough here to establish the basis for a paranoid personality. In other words, certainly Laura's mother had given her sufficient reason to become suspicious, ready to anticipate rebuff and to defend herself from possible accusations. On the other hand, Laura developed the habit of focusing on the bad qualities of her mother, magnifying them and overpreparing herself for attack. It could be that a few so-called white lies, similar to those told by many parents with the intention of pacifying their children, were interpreted by Laura as irrefutable evidence of her mother's mendacity and propensity for subterfuges. A vicious circle that perpetuated mistrust and abnormal sensitivity was

thus created.

However, the patient probably could have compensated for the anxiety of her childhood if fortunate circumstances in her later life had helped her. In fact, not everything was negative or destructive. She received a more than tolerant attitude and possibly some love from her grandmother. Her stepfather did not seem to resent her. In addition, Laura was able to find a field, classical dancing, in which she could express herself, and from which she received acclaim and gain in selfesteem. Her marriage, however, was an unfortunate event. At the same time that it deprived her of her theatrical career and artistic expression, it placed her in a situation where she again felt anxious and unwanted. Going to France, a foreign country, to live in a small town was like going once more to Germany after one of her visits in Vienna. Her mother-in-law and sister-in-law were other women in authority, ready to find fault with her actions, but mostly with her intentions. A woman coming from the theatrical world was not to be trusted. Her husband also vacillated in his attitude and favored his family too much.

The situation did not improve in America. The patient felt more

frustrated and disappointed. She had no interest in motherhood, possibly because the example of motherhood she had seen in her own mother was not an inspiring one. Her discontent and anxiety increased. These problems were accompanied by the realistic difficulties that the patient and her husband had to face in settling in the United States. Furthermore, living with her husband was a constant threat to her already unstable security. He was more and more critical of her, as her mother had been. She oscillated between believing him and increasing her self-image of the bad, worthless person, and repudiating him and defending herself from the accusations.

When the dog became sick and the patient's husband proposed having it destroyed, she identified the present situation with the one that had occurred with her dog in her childhood, which had caused her so much distress. She experienced horror. If nobody would be left to love her, if even the dog would be taken away, she would certainly feel alone, unloved, unlovable. A reactivation of the bad self-image that she had formed in early childhood and of all the unpleasant sensations undergone in that period took place (Chapter 8). But that unspoken, unverbalizable horror did not last long: a psychotic solution was

found. It was not true that she was worthless. The truth was that her husband was against her and what was dear to her. But even this idea could not be maintained. She displaced the threatening role from her husband to other persons, generally women, who could better be identified with her mother. The neighbor was reading her thoughts, as she once felt that her mother had done. The neighbor was doing even more: she was making a recording of her words and thoughts. Finally, there was a wide generalization when she thought that people were accusing her, that even the television programs were referring to her.

This case is fairly typical, and it reveals the basis for a selection of the paranoid pattern rather than the catatonic or hebephrenic. The factors which predispose to the paranoid type are the following. The important adults in the childhood of paranoids do not criticize the patients for their *actions;* they generally *accuse* the patients for their *intentions* or for *lying.* The child learns to defend himself, either by anticipating these accusations and therefore becoming anxious and suspicious, or by developing a facility for rationalizations. He has to find almost a legal or technical way to protect himself from insinuations and accusations.

Various trends may develop. The patient may become a submissive person who, although suspicious and living with the anxiety of being attacked, hurt, or accused, feels some guilt at the same time. As a matter of fact, he often oscillates between feeling misunderstood, guilty, inadequate, and "not good," and feeling unjustly accused, the victim of lies. He is generally compliant and fairly cooperative. These cases generally are benign and respond well to therapy.

In other cases, the desire of the patient to defend himself predominates; there is a certain pride and complacency in the way the patient defends himself from the accusers. Rationalizations and pseudological defenses are built up. Some of these patients may never become psychotic in a manifest way; on the contrary, their tendencies to find legal reasons for protecting themselves or accusing others may be channeled successfully into certain professions. At times their hostile allegations, based on half-truths and on distortions, may meet with popular favor and may help their careers. When they become psychotic, these patients are generally defiant and resistant to treatment. One of these types of paranoids is the "querulous paranoid." He feels that injustices have been perpetrated on him, and

he resorts to the law to defend himself. When he is defeated, he does not surrender but appeals as many times as the judicial system permits. With his pride in his knowledge of the law and his fanatic belief in his rights, he acquires at times almost a grandiose and manic flavor. Sometimes the diagnosis of manic-depressive psychosis with paranoid trends is made. French writers (Serieux and Capgras, 1950) call the querulous paranoids *maniaques raisonnants.* According to Mayer-Cross (1950), this type is not as common in England as it is in Germany. He states that the difference in incidence may be due to the fact that the Common Law does not elicit this type of reaction the way the codified system does; or that it may be due to the fact that the pathological nature of these reactions is not as easily recognized in England as in Germany. In my own experience, I have found that this type of paranoid is not rare in the United States. I have come in contact with several cases.

Other patients, instead of focusing their attention on their pseudorational defenses, seem to sense or magnify any kind of hostility in the environment. At times this hostility is real and is caused by the attitude of the patient; at other times it is just a mild hostility that accompanies many actions of normal people. The paranoid is

sensitized to this hostility; he magnifies it and generalizes it. He feels *pushed around,* pressured. The pressure that, as a child, he experienced as coming from the malevolent, hostile, and inconsistent parent is now generalized to a great part of humanity. In some of these cases any interpersonal relationship increases the anxiety and enhances paranoid developments. This tendency may make psychotherapy very difficult or impossible.

Because classic psychoanalytic literature has stressed so much the importance of latent homosexuality in relation to paranoid states, we shall discuss again here what we have mentioned in Chapter 8 in reference to this topic. Latent homosexuality is a relatively frequent factor, but not a necessary one, in paranoid conditions. It leads to paranoid conditions, not because it is an inherent part of the paranoid process, but because homosexuality engenders a great deal of anxiety in many people. The latent homosexual tries to deny his own homosexuality because this form of sexuality is not accepted by society. In certain situations, however, as when he encounters a person to whom he is particularly attracted, he cannot deny his feeling to himself. He feels that he is succumbing to his impulses, and in order to avoid doing so he may resort to psychotic denial. The loved person

becomes the persecutor, as Freud illustrated in Schreber's case. The patient no longer accuses himself of any homosexual desires, but other people do accuse him of awful things, as, for instance, of being a spy. The parents or their symbols enter the picture again; they accuse him of being a "bad child." He is bad, he is homosexual, he is a murderer, a spy. All these accusations are emotionally equivalent. It is generally assumed today, although with insufficient evidence, that no homosexuality, even at a latent state, would have originated if the patients had had healthy interpersonal relationships with their parents or parent-substitutes (Bieber et al., 1962). Not all persons who deny homosexuality become paranoids; not all paranoids are latent homosexuals. Furthermore, in a society where this form of sexuality would be more acceptable, there would be fewer persons who, on account of these latent leanings, would develop the intense anxiety which leads to psychosis.

As already mentioned in Chapter 8, uncertainty about one's own sexuality and a general sexual maladjustment, rather than a clear-cut homosexual pattern, are the psychosexual pictures more frequently found in the paranoid.[2]

Under the paranoid classification are to be included the cases *oi folie a deux* or *folie a trois.* In these instances we have the simultaneous occurrence of two or three cases of paranoid conditions in the same family or household. The situation is generally the following. The first one to become sick is usually a person with a strong, overbearing, arrogant personality. He is able to make the spouse, a child, a brother, a sister, or a friend living on the same premises accept his own delusional system. The recipients are generally weak, submissive persons who find it easier to accept the ideas of the donor, even if they are psychotic, than to fight them. The unshakable conviction of the donor, as well as the anxiety that a rejection of his authority would provoke in the recipients, makes the latter accept his delusions. Of course, the recipients must be predisposed by their own psychological difficulties (such as an extreme state of dependency, and so on) to accept the psychotic burden of someone else. Gralnick (1942) has made an accurate dynamic study of these cases. The prognosis is good for the induced cases if they are separated from the donor and receive adequate therapy. Layman and Cohen (1957) reported the history of two brothers who developed *folie a deux.* Dawson and Burke (1958) reported the cases of a husband and wife whose joint delusions met

the intrapsychic needs of both. It is questionable whether we could speak of real schizophrenia in the recipient.

Notes

[1] Drug therapy was not yet in existence when this patient became ill.

[2] Other authors (Klein and Horwitz, 1949; Tyhurst, 1957) have experienced similar doubts about the necessity of the association homosexuality-paranoid condition.

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