Freeman, T. (1988). The Delusions of the Non-Remitting Schizophrenias: Parallels with Ch... Bul. Anna Freud Centre, 11:217-227.

Bulletin of the
Anna Freud Centre

(1988). Bulletin of the Anna Freud Centre, 11:217-227

The Delusions of the Non-Remitting Schizophrenias: Parallels with Childhood Phantasies

Thomas Freeman

M. Bleuler's **(1978)** follow-up studies have confirmed the clinical observation that the course of the illness in non-remitting schizophrenias is towards the establishment of relatively stable 'end states'. The term 'end state' as used by **M. Bleuler (1978)** does not mean that the process of illness has come to an end, is incapable of further development for good or ill, or that further changes may not affect the personality. Only when the illness has continued in this relatively steady condition for five years can it be designated an 'end state'. Although acute attacks may occur during 'end states' they are ephemeral and there is a return to the quiescent condition. M. Bleuler distinguishes three types of 'end state': severe, moderately severe and mild. Dementia and defect state were the terms used in past times to describe the first two. The third type consists of those patients whose illness is not immediately obvious, who can conduct a rational conversation without the intrusion of delusional and hallucinatory experiences and can undertake useful work.

I

The delusions which occur during the initial, acute attack of a schizophrenic psychosis are inclined to disappear along with other acute manifestations **(E. Bleuler, 1911)**. In contrast the delusions which make their appearance when the illness follows a chronic course (non-remitting) tend to persist unchanged over many years **(E. Bleuler, 1911)**. The introduction of drug therapy has not altered this apart from causing a transient disappearance of the delusions. The long-term observation of schizophrenic patients, whose illnesses have reached 'end states', suggests that the content of the delusions is different from that present during the initial attack.

The delusions to be described here are drawn from twelve cases, four of which had reached a severe 'end state' (three women and one man); six had reached a moderately severe 'end state' (four women and two men); and two, a mild 'end state' (one man and one woman). The retrieval of the delusions was sometimes easy, but occasionally very arduous. The greatest difficulty was encountered when there was inattention, withdrawal and cognitive disorganization. The presence of thought-blocking, derailment of speech, the inappropriate

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

use of words (loss of the symbolic function), aberrant concepts **(Schilder, 1923)** and neologisms combined to conceal the content of delusions (Freeman, 1963). Perseverations, transitivistic phenomena and appersonations expressed in speech, contributed to the confusion caused by the breakdown of syntax. The recovery of delusions in such severe 'end states' can therefore only be accomplished piecemeal. Fortunately there are occasions, however brief, when speech regains its communicative function and a detail of the patient's delusional reality makes its appearance. These are occasions when the patient has a pressing need or is angry because of a disappointment **(Freeman, 1969)**.

Although patients whose illness has reached a mild 'end state' can communicate verbally when they so desire, it is unusual for them immediately to reveal the details of their delusions. The reticence tends to disappear when they discern that an interest is being taken in their circumstances. After some weeks, however, a reluctance to continue with daily sessions begins to appear. Patients fear that they are wasting the psychiatrist's time. Then they either stop attendance or become increasingly withdrawn. The psychiatrist may be accused of exerting a malevolent influence. Such a sequence of events occurs despite the chemotherapy. After a few weeks it is sometimes possible to re-engage patients in further meetings. However after a short while the reluctance and withdrawal appear once more.

Common to the twelve patients were delusions whose content consisted of wishes fulfilled. A male patient (severe 'end state') claimed that he had found the hospital in ruins and had restored it. Another male patient (moderate 'end state') believed that he had invented machines of inestimable value to society; another man (moderately severe 'end state') that he had uncovered a criminal conspiracy to destroy the world. The wish phantasies of the female patients were of a romantic-erotic nature (see **Bleuler, 1911**). The delusional phantasies of the mild and moderately severe 'end states' were internally consistent and constant. Erotic phantasies were also found in male patients. The beloved, in both male and female patients, was usually known either before or shortly after the onset of the illness. In severe 'end states' the erotic phantasies were ephemeral, and fragmentary. The lovers who appeared miraculously in the night had never been known.

In every case the patients blame persecutors for their being deprived of the fruits of their achievements and of their lovers.

Persecutors had caused them to be confined in hospitals or placed in hostels. Those enemies were often known to the patients. Sometimes it was the parents who were blamed but many patients denied their parentage. Their real parents were persons of importance. As has been described these complaints did not

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.
- 218 -

necessarily lead to anger but they could do so, as will be illustrated below.

The delusional reality in some cases, has a distinctive feature. In two of the female patients, one having reached a severe 'end state', there was an imaginary person (a 'delusional object') who played an important part in the patient's life. In the first case the imaginary figure was a male teacher at the school the patient had attended as a child. He talked to her. Sometimes he was complimentary, at other times critical. She looked to him for advice. She said, 'Mr X [the teacher] does not allow me to speak to them [the other patients]…he asks if I am being polite.' During meetings with this patient, there were occasions when she appeared to be playing the part of the schoolmaster, or the writer was allocated this role.

In the second case the imaginary figure was a woman doctor. The discovery of this 'delusional object' occurred unexpectedly when the patient was sought out after a break in the daily meetings which had been going on for at least three months. She did not want to speak and shouted angrily, 'I don't like you, you don't follow me, I only like my own doctor.' Enquiry eventually revealed that this doctor had been the family practitioner but the patient had not seen her for many years. Her 'doctor' assumed full responsibility for her. She told her when to wash, when to shampoo her hair, change her clothes, when to eat and when to go to the lavatory. These hallucinated instructions explained her frequently occurring active and aggressive negativism.

The wish delusions of 'end states' were not in evidence during the initial, acute attacks of the illness. At the onset the delusional ideas were predominantly persecutory. Many patients believed that perverse sexuality or promiscuous tendencies were being imposed upon them by persecutors, known or unknown. These delusional ideas disappeared after the first or second relapse. A case in point is that of a young man who believed that others regarded him as a homosexual. Following a remission which lasted about eight months he fell ill again. This time there was no longer any concern about homosexuality. Instead he was preoccupied with thoughts about a girl he believed was in love with him. He accused his parents of hospitalizing him to prevent him seeing the girl. This delusion (erotomania) became part of a more complex psychotic reality which developed as time passed.

Inherent in the delusional reality of 'end states' is omnipotence and control. Any event or experience which runs counter to the omnipotent phantasies is denied. Delusional ideas of this kind are the counterpart of 'passivity' experiences. The polarity—controlling and being controlled—is derived from the observation that patients who in 'end states' claim such powers, are those who complained of passivity experiences in their first attacks. For example, a male

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.
- 219 -

patient whose first attack had been characterized by passivity experiences claimed, when his illness reached an 'end state' (moderately severe) that he had detected the existence of master criminals who secretly, and unbeknown to their victims, caused them to carry out robberies and murders for their own gain: 'They move them about like puppets,' he said. He was immune to their influence although they were forever trying to gain control over him.

It is usual for acute attacks of short duration to occur during 'end states' **(M. Bleuler, 1978)**. Persecutory ideas, hallucination, withdrawal, agitation and negativism may constitute the symptomatology. Such acute phases occurring during 'end states' have as their immediate causes affects provoked by changes in routine, by real or unreal expectations and disappointments **(E. Bleuler, 1911)**. When patients are seen on a regular basis, an opportunity is afforded of witnessing the stimulus which leads to these acute episodes. The fact that patients in 'end states' believe that their wishes have been fulfilled leads to expectations which in the nature of things cannot be met. A male patient (severe 'end state') believed that he was owed large sums of money. Once given the money he would marry the girl who he believed loved him. When this man was asked to participate in regular meetings he readily agreed. Only later did it become apparent that the willingness arose from the expectation that the writer could get the money for him. After several months of daily meetings, he became withdrawn and negativistic. At first sight there was no apparent cause for this reaction. Later, however, he berated the writer, accusing him of failing to keep his promise to get him the money. A female patient (mild 'end state') refused to leave the house because she heard a neighbour calling her a prostitute. She had recently been in hospital for a minor operation, where she met a man who, she concluded, found her attractive. This information was revealed only reluctantly.

II

There is agreement that the delusional reality of established cases of schizophrenia is in the nature of a substitute for material reality (**Bleuler, 1911**; **Freud, 1911**; **1923**). This theory implies that the wish delusions compensate for and protect against an external reality which is viewed to be dangerous and frustrating. Regarded in this way the wish delusions reinforce the protection initially provided by the break with reality which **Bleuler (1911)** described as the negative element of autism and **Freud (1911)** as the withdrawal of object cathexis. Despite this, patients in 'end states' are not spared bouts of 'persecutory anxiety' in the manner already

described. This reveals that the wish delusions which form the nucleus of the

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

psychotic reality are by themselves unable constantly to maintain the defence against the dangers evoked by the derivatives of instinct.

It is the protective or defensive use of wish delusions which led **Anna Freud (1936)** to compare them with certain kinds of childhood phantasy. The similarities extend beyond content to sources and manner of formation. Some children employ phantasies to relieve objective anxiety and pain **(Anna Freud, 1936)**. A child's fear that his jealousy and envy of the father will lead to retribution initiates a series of unconscious mental events (displacement, reversal) designed to dispel objective anxiety. A dangerous animal substitutes for the frightening father and, its nature changed, becomes a friend and protector over whom the child has complete control. This substitution also occurs during the psychoanalytical treatment of children when fear of the father, arising from the projection of the child's hostility, is displaced on to the person of the analyst. To ward off fear of the analyst the child makes use of toys and imaginary figures to protect him and control the analyst. In the case of objective pain, the child's sense of helplessness vis-à-vis the parents is removed by removing the true nature of things. Denial of reality is achieved through wishful phantasies in which the child assumes directly or through the medium of imaginary figures the power and strength of the father whom he both fears and loves. The control over the father which the child gains through wish phantasies is no different in nature to the omnipotence and omniscience which is at the core of the wishful delusions of patients in 'end states'.

Children also make use of wish phantasies to deny real, distressing events **(A. Freud, 1973)**. The father of a little boy, Bertie, aged four and a half, was killed in an air-raid **(A. Freud, 1973)**. In the weeks following this tragic event he repeatedly talked of his father as alive. His father had gone off to work in his raincoat and hat because it was raining. When he did not return Bertie said that he put on his coat and went to look for him. After finding him he brought him home. This phantasy of rescuing the father had further expression in a phantasy of being the driver of a fire-engine. He put out fires, rescued people and took them quickly to the doctor. In a game in which he built houses and knocked them down with marbles, representing bombs, all the people were saved. This outcome was in contrast to other children who, playing a similar game, said the people were killed. Bertie's game had the purpose of denying what had happened in reality: the death of his father in an air-raid. Its compulsive nature betrayed the fact that the denial was becoming less successful **(A. Freud, 1973)**. This little boy's phantasy in which he omnipotently restored the houses and saved the people is identical to that of the chronically ill schizophrenic patient who claimed that he had rebuilt the hospital and restored the inmates to health after the hospital had been destroyed.

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

A similar sequence of mental events is to be found in patients who fall ill with a maniacal illness following a bereavement or a disappointment in love. Denial of the loss of the love object is achieved by wish phantasies replacing reality. The love object has not gone away and in proof of this the patient insists that he has seen him or her, or has heard their voice. Other patients, nurses and doctors are misidentified as the lost love object. These wish delusions disappear with the remission of the maniacal attack. However, they become permanent in the mental life of schizophrenic patients whose illness was initially precipitated by the loss of a real love object. A young woman in her early twenties was jilted by her fiancé. After some months she came to believe that her former fiancé was trying to contact her. Her belief that enemies were preventing them from coming together led to her hospitalization. After two periods of partial remission the illness entered into a chronic stage (moderately severe 'end state') which was characterized by short-lived bouts of persecutory ideas. At the centre of the psychotic reality was the delusion that she was married and had a son. Her husband was a doctor. She had met him in one of the hospitals in which she was a patient. The doctor had taken the place of her former fiancé. She claimed that the family solicitor had a box in his possession which contained her marriage certificate and a boy's suit. She and her husband had had to separate because of her family's disapproval and opposition. Her brother had recently introduced her to a young man whom he encouraged to make sexual advances to her. She knew that her husband was constantly trying to get in touch with her but he was prevented from doing so by her mother and brother.

III

There is another type of childhood phantasy which has a relevance for the psychotic reality of schizophrenic patients. This is the imaginary companion (**Sperling, 1954**; Nagera, 1968) and the phantasy of having a twin **(Burlingham, 1952)**. Imaginary companions occur in children between the ages of two and a half and three, and between nine and ten. In some cases the phantasy persists into adolescence and there have been reports of it continuing into adult life. In contrast to other childhood phantasies the imaginary companion occupies a physical space in the child's world. It has a special intensity and vividness.

The content of the child's interaction with his or her imaginary companion—what the companion says, how the child responds and how he perceives the companion—has led to the following conclusions **(Nagera, 1968)**. In young children the companion's help is required for the control of wishes and needs which would lead to

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

conflict with the parents (external conflict). This assists the process of internalization of restraints on 'instinct'. In older children the companion acts as a 'prop' for the newly emergent superego. The companion can express those wishes and actions which are unacceptable to the child. Here the companion is blamed by the child for actions he undertook and for which he has been criticized. The companion may therefore come to play the role of scapegoat.

In his study of the imaginary companion Nagera (1968) has drawn attention to the fact that the companion makes his or her appearance when children feel lonely, neglected or rejected. Thus the birth of a sibling is often the occasion for the emergence of the imaginary companion. However, a companion may appear when children are confronted with real object-loss or suffer when they feel threatened by their helplessness to influence the behaviour of adults. It is in these instances that the phantasy of the imaginary companion or twin acts as a protection and a defence. **Sperling (1954)** describes the case of a boy of four who would only speak and act if his imaginary companion, Rudiman, gave permission. Rudiman was taller and stronger than his father. His voice was so loud that the boy had to cover his ears when he spoke. This imaginary companion allowed the child to sustain the illusion that he was independent and free of his father's control. In this way reality was reversed and denied. In common with other companions, however, Rudiman would be blamed for encouraging 'anti-social' acts.

Delusional figures analogous to imaginary companions are periodically found in long-standing cases of schizophrenia. The delusional object, like the imaginary companion, may act as an external authority and guide and, like Rudiman **(Sperling, 1954)**, give the patient the illusion of being independent of the requirements of the nursing staff. The delusional object is never blamed for unwanted speech or action, as happens when persecutors, known or unknown persons, are blamed for 'passivity' experiences.

There was nothing to suggest, in the two cases described earlier, that the delusional objects had imaginary companions as childhood precursors. Such a psychopathological development was encountered, however, in a woman patient aged 34 who was hospitalized on account of an acute psychotic attack characterized by auditory hallucinations. The patient was married with two children. She complained of a female voice in her head. The voice instructed her to act in a manner which caused her great distress. The voice told her to strike her husband and throw tea over a newly painted wall. The voice instructed her not to speak, told her to sit still or go for a walk. It also criticized her appearance, commented on her actions and recalled painful memories of childhood. She became frightened when the voice told her to kill herself.

The patient said, at first, that she had become aware of the voice in her head when she suspected that her husband was showing

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

an excessive interest in her sister, who was separated from her husband. She asked her husband to promise not to have any contact with her. After some time she discovered that he was indeed having an affair with her sister. The voice had already been telling her that this was so, and it reminded her of actions which indicated that he no longer loved her. The voice encouraged her to act violently toward him. She became fearful lest she might give way to those provocations and kill her husband.

During regular meetings with the writer she recalled that as a very young child, the youngest of three children, she had been extremely close to her mother. Later this changed, and this, according to the patient, was due to a serious deterioration in her home. This led to bitter rows between the parents with the husband accusing his wife of infidelity. The patient felt alone and neglected. When she was approximately eight or nine years of age an imaginary companion appeared on the scene. The companion, a girl somewhat older than herself, comforted her when she was lonely. They talked together and played games. The companion reassured her when she felt afraid at night. Sometimes, however, the companion would make her afraid, telling her to frighten her mother by running away from home or encouraging her to bang her head against the wall.

The companion remained with her until she was about sixteen. At this time she began to make friends for the first time, and as these friendships developed the companion faded and disappeared. When, at the age of twenty, she met her husband, she felt that at last she had found someone in whose life she would be first. As memories of her disappointment in her husband returned, she recalled that when she discovered he was losing interest in her, the imaginary companion returned to comfort and console her. However, within a short time the companion began to criticize the husband and remind the patient of his shortcomings. Imperceptibly (or so it seemed to the patient in retrospect), the image of the companion faded, leaving only the disembodied voice whose utterances were described above.

In this case the 'persecutory voice' developed out of the imaginary companion. The hatred which the patient unconsciously felt for her husband was attributed to the new version of the companion, in much the same way as the young child regards his companion as the source of all those wishes which he has come to fear. In childhood this patient's imaginary companion became the focus of the libidinal cathexes withdrawn from a mother perceived as rejecting. In adult life, it came to act as a vehicle for aggression, as it had done, on occasions, in childhood.

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

The young child's use of wish phantasies to deny an unacceptable reality is an aspect of normal ego development **(A. Freud, 1936)**. Young children can reconcile the contradictions which exist between the psychical reality afforded by wishes and material reality. This is true in the case of imaginary companions. However, such contradictions become untenable as reality testing increasingly establishes itself. This is not to say that wish phantasies are no longer evoked to soften the impact of disappointments, frustrations and object loss, but they make no impact on the way the individual perceives himself and others **(Freud, 1916)**. As **Anna Freud (1936)** says, ‘the original importance of the day-dream as a means of defending against objective anxiety is lost when the earliest period of childhood comes to an end’.

The psychotic reality of patients whose schizophrenic illnesses have reached ‘end states’ reveals that, like small children, they are not dismayed by the fact that the reality created by their wishes cannot be reconciled with external reality. It is the existence of the two realities, as in the phenomenon of ‘double bookkeeping’, which led **Bleuler (1911)** to suggest that ‘systematic splitting’ is the characteristic clinical feature of the schizophrenias.

At first sight it would appear as if the psychotic reality has resulted solely from the re-emergence of a childhood mode of mental activity (denial in phantasy) which is no longer appropriate and adaptive (Jackson, 1984). However, wish phantasies are freely employed to counter frustrations and disappointments in both the healthy and in those who suffer from symptom and other character neuroses (see **Freud, 1916**, and his concept of introversion). It may be that the measures employed to counter objective pain **(A. Freud, 1936)**—measures of displacement or reversal—are predominant elements of the defence organization of the pre-illness personality of those whose schizophrenias proceed to ‘end states’. It is patients such as these whose pre-psychotic personalities are often described as schizoid-pathological **(Bleuler, 1978)**. Omnipotence—overt or covert—is a feature of such personalities. Could this omnipotence be the result of a heightened sensitivity to perceptions which evoke objective pain?

The fact that wish phantasies exist and act defensively, as they can do, indicates that their content has been successfully disconnected from wishes which evoke anxiety. Clinical work with young children and schizophrenic patients has shown that these protective wish phantasies can be swept aside and replaced by anxiety. A girl aged four who was undergoing psychoanalytic treatment (Novick, 1974) was able to deny her physical immaturity vis-à-vis her mother by means of a pregnancy phantasy. A

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

chronically ill schizophrenic patient denied his ‘incarceration’ in the hospital by means of the delusion that he controlled the routine of the institution. When the child patient and the adult schizophrenic patient became anxious the defensive phantasies disappeared. The little girl feared that she might harm the analyst with the flatus she passed *per anum* during the session. This reflected her unconscious wish to destroy her love object with faeces. The schizophrenic patient dreaded that, in the course of defecating, he had generated a wind which had destroyed the countryside. These pregenital wish phantasies are clearly of a different order from those which serve defensive aims. This replacement of the latter by the former may be observed in psychotherapeutic work with established cases of schizophrenia and during the psychoanalytical treatment of young children. The reversal mechanism no longer operates, leaving the patient with the perception of the psychiatrist or analyst as hostile or dangerous. A female schizophrenic patient engaged in psychotherapy responded with an erotomanic delusion: that the psychiatrist was in love with her, was going to marry her and give her a child. After some weeks she refused further meetings, accusing the psychiatrist of secretly giving her a drug which rendered her helpless and raping her. He had infected her with syphilis and aborted her pregnancy. It would appear, therefore, that in the case of the schizophrenias which reach ‘end states’, defensive wish phantasies will only maintain themselves as long as interpersonal contacts which provoke the arousal of dangerous wish phantasies can be avoided.

References

Bleuler, E. (1911). Dementia Praecox. New York: Int. Univ. Press, 1951
Bleuler, M. (1978). The Schizophrenic Disorders. New Haven: Yale Univ. Press
Burlingham, D. (1952). Twins. London: Imago
Freeman, T. (1969). Psychopathology of the Psychoses. London: Tavistock
Freud, A. (1936). The Ego and the Mechanisms of Defence. London: Hogarth
Freud, A. (1973). Infants Without Families and Reports on the Hampstead Nurseries 1939-1945. London: Hogarth

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

Freud, S. (1911). On the autobiographical account of a case of paranoia. Standard Edition 12 [→]
Freud, S. (1916). Introductory lectures on psychoanalysis. Standard Edition 16 [→]
Freud, S. (1924). The loss of reality in neurosis and psychosis. Standard Edition 19 [→]
Jackson, J. Hughlings (1894). The factors of insanities. In Selected Writings, 2. New York: Basic Books
Nagera, H. (1969). The imaginary companion. *Psychoanal. St. Child*, 24, 165-196 [→]
Schilder, P. (1923). Medical Psychology. New York: Int. Univ. Press, 1951
Sperling, O. (1954). An imaginary companion, representing a prestage of the superego. *Psychoanal. St. Child*, 9, 252-285 [→]

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

Article Citation [Who Cited This?]

Freeman, T. (1988). The Delusions of the Non-Remitting Schizophrenias: Parallels with Childhood Phantasies. *Bul. Anna Freud Centre*, 11:217-227

Copyright © 2009, Psychoanalytic Electronic Publishing.

Help | About | Report a Problem

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.