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TREATING CHRONIC SCHIZOPHRENIA AND COMPLEX TRAUMA THROUGH JUNGIAN DREAMWORK: A PRISON-BASED CASE STUDY

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Abstract

This case study documents the integrative treatment of a woman with chronic schizophrenia, complex PTSD, and comorbid anxiety and depression, incarcerated during the COVID-19 pandemic. Her primary symptoms included persistent hallucinations, trauma-driven nightmares, and emotional dysregulation. Traumatic themes of incest, supernatural forces, and violent dream figures dominated her inner world, exacerbated by institutional isolation, grief over a deceased brother, and unresolved family betrayal. Treatment combined Jungian dreamwork, guided hypnagogic induction, symbolic reframing, and trauma-focused narrative therapy. Hallucinatory content was interpreted as disowned psychic fragments; she was taught lucid dreaming, meditative coping skills, and dream preparation rituals. Through these techniques, she gained increasing agency in her dream life and began re-integrating dissociated parts of the self. Art assignments and metaphor-based dialogues enabled her to visualize and confront the "poltergeist" figure (a

symbolic condensation of unresolved trauma and fear). Parallel work focused on dismantling distorted family loyalty and confronting historical abuse. She ultimately rejected financial dependency on her abuser, reasserted personal boundaries, and re-engaged with psychiatric care after initial resistance to medication. Her hallucinations diminished, and she reframed residual trauma as material for growth rather than doom. This case illustrates the power of symbolic and integrative interventions in treating schizophrenia complicated by developmental trauma. It further highlights the therapeutic challenges and innovations necessitated by pandemic-era incarceration.

Keywords:
Chronic Schizophrenia, Complex PTSD, Dream Work, Prison Therapy, Symbolic Integration, Trauma, Hallucinations, Jungian Analysis

1. Introduction

During the height of the COVID-19 pandemic, I was working as a therapist in a Texas women's correctional facility. Visitation was suspended. Inmates were cut off from the outside world, their only connection to current events being the flickering television in the dayroom. News reports showed mass graves, ventilator shortages, and widespread collapse. Rumors circulated that one-third of the global population might die. Fear, isolation, and disconnection pervaded both inside and outside the prison.

In this setting, mental health referrals were often inmate-driven. Trustees and peer support workers would quietly pass along the names of individuals in distress. One name surfaced repeatedly: Luna. She had reportedly stopped leaving her cell. Inmates said she whispered to herself and spoke to ghosts. Her bunkmate requested to be moved. She was described as "possessed." I asked a trustee to pass her a permission slip. The next day, Luna arrived at my small, windowless office.

2. The Arrival

Luna entered cautiously, her eyes scanning the corners of the room as if watching for something to emerge. When I invited her to sit, she moved quickly and pressed her back against the farthest wall. I introduced myself and explained I was there to help. She nodded but remained silent. Her body language suggested intense fear. I gently asked what she was afraid of. After a pause, she said quietly, "It's hard to explain, but I think I'm seeing demons."

She shared that she had started using methamphetamine in her twenties, primarily to stay awake. Sleep brought nightmares she could no longer tolerate. Over time, the boundary between sleep and waking collapsed. She had never received a coherent explanation of schizophrenia or psychosis. At the time we met, she was suicidal. Her voice cracked when she said, "I'm in hell. I don't even know what's real anymore."

3. Illumination

I began with basic psychoeducation. We reviewed the criteria for schizophrenia and mapped how they aligned with each of her symptoms (American Psychiatric Association, 2013). She identified strongly with the descriptions. Luna was Catholic, and while religious frameworks are typically respected in therapy, the immediacy of her risk, actively suicidal and functionally

delusional, necessitated a temporary departure from spiritual validation. I explained the mechanisms of psychosis and emphasized that the demons and ghosts she perceived were only hallucinations. I introduced the hypnagogic state as a liminal space between waking and sleep, where sensory processing often becomes blurred. I suggested that her mind might be stuck in this threshold when she hallucinated.

She looked at me with faint hope and asked, "So you're saying none of this is real?" That was the first crack in the delusional framework. She began to ask more questions.

4. Meeting the Shadow

As our therapeutic rapport deepened, I introduced foundational concepts from Jungian psychology (Jung, 1964; Hillman, 1979; Kalsched, 1996). I explained that monsters often symbolize disowned parts of the self, rage, grief, shame, that have been split off and return in symbolic form when the psyche is overwhelmed. "You don't fight them," I said. "You ask what they want."

I shared a personal dream I had in college, where I was chased by a monstrous figure. When I finally turned to confront it, it transformed into someone in an Eeyore costume. I removed the head and saw a disabled boy I had known in childhood. He had attended my sixth birthday party. I told Luna that trauma can lead to parts of the psyche becoming arrested in development. The monster, I suggested, was a part of me.

Luna was quiet for a long time. I suggested, if the shadow figures returned, try asking what they want.

At our next session, she reported that one had emerged from her cell wall. Instead of hiding, she had stood up and asked, "What do you want?" The figure did not attack or vanish. It melted away.

"Like it had never been there," she said.

She began to sleep. Her hallucinations decreased. Her voice became more grounded. Her posture improved. And she began recalling memories from her childhood.

5. Symbolism Revealed

Over time, Luna shared a memory from when she was nine. Her thirteen-year-old half-brother would climb into her bed at night and rape her. He would then cry on her chest and say,

"The devil made me do it," begging her not to tell. When the family noticed something was wrong, they did not ask questions. He was sent away for a while but returned without explanation. Holidays, birthdays, and family events continued as if nothing had happened.

Luna said the whispering voices reminded her of his voice in the dark. The eyeless shadow figures were how he looked in the dim light. Her hallucinations were not meaningless; they were encrypted trauma (Moskowitz et al., 2009; Van der Hart et al., 2006).

6. The Voices

As Luna's visual hallucinations faded, the auditory ones intensified. She heard voices calling her name with relentless repetition. Some accused her of unspeakable things. Others simply whispered until she covered her ears and screamed. "They're worse than the demons," she said. "They're everywhere." She hid under her sheets, pressing a pillow to her ears in a desperate attempt to make them stop.

I reminded her of her success with the shadow figures (Corstens et al., 2014). I suggested that she treat the voices the same way, chase them down, ask them what they wanted. She had her doubts, but she was starting to trust the process.

A week later, she returned with a report. It worked. The voices were mostly gone, and when they returned, she was able to drive them out. She stopped talking to herself and started socializing in the dayroom. The other inmates began accepting her.

Then COVID mutated again. The prison went into full lockdown. No therapy sessions. No shared spaces. No contact. For months, there was silence.

When Luna returned, she looked like someone else.

7. Descent into Nightmare

Her body was the same, but her eyes were dull. She described a recurring nightmare that had begun during the lockdown. In the dream, she was back in her childhood home. The doors and windows were boarded up, and the house was flooding with water. Something pounded at the walls, trying to get in as she ran from room to room.

She feared sleep more than waking life. The hallucinations were gone. The threat had shifted. It now lived in her dreams.

8. Dream Warrior

Luna told me she no longer wanted to sleep. Each night, the same nightmare returned: boarded windows, rising water, and a violent presence pounding from outside. It was the same terror that had once driven her to meth.

I introduced her to lucid dreaming (Spoormaker & van den Bout, 2006). I explained that it might not offer full control, but it could allow her to act within the dream. I taught her to use reality checks, look at her hands, try to read a clock, count her fingers. These cues often fail in dreams and can trigger lucidity.

I also warned her that for people with schizophrenia, lucid dreaming might briefly increase distress before it offers relief.

She took it seriously. She kept a dream log and practiced her cues.

Eventually, it worked. She became lucid. She looked at her hands and noticed something was wrong. She saw the shadow figure and walked toward it.

This time, it did not dissolve. It lunged at her. She said it felt more real than any hallucination she had ever had. She woke up screaming.

At our next session, she slumped in her chair. “It didn’t work,” she said. “I knew I was dreaming. I faced it. It still attacked me.”

I told her that lucidity does not erase fear. It reveals it. And sometimes that is worse.

9. The Turning Point

She stopped sleeping entirely. She missed sessions. Her voice lost its rhythm and energy. Her humor disappeared. “I can’t take this much longer,” she said.

We revisited the topic of medication. She had always refused. She feared sedation, weight gain, and the loss of control. This time, I showed her side-by-side photographs of brains: one from a person with untreated schizophrenia, the other of a healthy brain. The untreated brain showed clear signs of atrophy. The other looked intact, integrated.

She stared at them a long time. “Is that what happens if I stay like this?” she asked.

“Yes,” I told her. “Eventually.”

She agreed to meet with the psychiatric nurse and began medication.

Within weeks, her sleep returned. Her dreams softened. She came back to therapy with brighter eyes. Her voice had inflection again. Her mood lifted. The dreamwork continued, and her nightmares became more manageable.

10. Renewal

Over the following months, the combination of therapy, lucid dreaming practice, and medication led to steady improvement. Luna began drawing again. She laughed in session. She became social in the dayroom.

Then she walked in one day beaming. She had received official notice of early release due to COVID-related depopulation efforts.

She now faced a new decision: whether to move into a halfway house or live with family. She expressed skepticism about halfway homes, calling them chaotic and often filled with drugs. But returning home was complicated.

Her half-brother, the one who had raped her, was part of the family again. He had married, had children, and regularly wrote to her from prison. He also sent her money. “He always apologizes,” she said.

Despite everything, she wanted to go home.

11. The Poltergeist

Within weeks of receiving her early release notice, Luna’s nightmares changed again. The specific demons were gone. Instead, she described something amorphous: a miasmal poltergeist, a black fog that followed her through dreamscapes. It did not speak. It did not take form. It simply pursued her through the streets, filled with chaotic, undefined evil. It consumed rather than attacked. There was no logic, no confrontation, only dread.

She dreamed of watching her family walk into the fog. She called for her mother, but when her mother turned around, her eyes were vacant. Everyone touched by the fog became possessed.

Luna began missing sessions again. Even with medication, her energy faded. She withdrew.

I recognized this as an archetypal descent, a symbolic death (Hillman, 1979). Previous figures had forms, names, and meanings. This fog had none. It was undifferentiated. A psychological miasma. A loss of self.

We pivoted the work toward emergency-level interventions. I taught her how to ground herself in dreams: to picture her prison bunk, to repeat "wake up, you're dreaming," to focus on her breathing. I showed her how to use sensory triggers to bridge waking and dreaming states.

These tools helped at times, but not always. She said she was exhausted. "I don't want to run anymore," she told me.

12. The Reveal

After missing several sessions, Luna showed up unannounced. Her posture was collapsed, her eyes shadowed. She said she needed to confess something she had not shared before.

At age twenty-five, during a family reunion, she had fallen asleep on the couch. Her family had spent the day drinking. Late that night, she awoke to find her clothes being removed. Her half-brother, the same one who raped her as a child, was on top of her.

She fought him off, but he followed her through the house, whispering her name, trying to convince her to let him continue. She locked herself in her childhood bedroom, holding the door shut with all her weight for nearly an hour. He eventually forced his way in and wrestled her to the ground. She managed to escape, screamed until the family woke up, and told them he was trying to rape her.

They made him leave that night. Two weeks later, he was arrested for murdering a gas station clerk for $200. He served thirteen years and was now out. He had a wife and children. He had resumed contact with Luna through letters and money.

She told me, with visible shame, that she had been working at a strip club at the time. Her family assumed she had been prostituting. She wondered aloud if this had justified, in his mind, what he did.

I interrupted her gently but firmly. I reminded her that nothing she had done justified being raped. Not then. Not ever. I told her she was not to blame.

13. The Final Push

We spent several sessions processing this. Suddenly, her dreams made sense. The poltergeist was no longer an abstraction. It represented her brother, and the part of her family that had reabsorbed him without acknowledging her pain.

The dream where her mother entered the fog and returned vacant was not symbolic. It was literal. Her mother had chosen not to confront what happened.

We agreed that going home was unsafe. She would write a letter. In it, she would share everything, including the assault at twenty-five. She would explain that she could not be around her half-brother again. She would not issue an ultimatum, but she would set a boundary.

We also researched halfway houses. I helped her identify one with a good reputation, located far from her family and from her old life. She began preparing herself for both possibilities.

14. Resolution

Luna showed up early for our final session. Due to COVID protocols, we had been moved to a larger room with windows. For the first time, sunlight touched the floor tiles.

She was glowing.

She told me her family had responded to the letter. They promised she would never have to see him again. They had chosen her.

She was still on medication. She still had occasional nightmares. But she was no longer afraid of her mind. She understood her symptoms now. She could interact with them, interpret them, and reframe them.

She had faced the hallucinations, the nightmares, the archetypal fog, and the man who had nearly destroyed her, and come through with a story that was her own.

I told her I was proud of her. She smiled and said thank you.

15. Clinical Reflections

Luna’s symptoms did not disappear. They moved. Her visual hallucinations gave way to voices, which gave way to nightmares. This shifting architecture reflected a dissociative structure. By tracking the migration and adjusting the approach, therapy remained aligned with her inner world. It was not static. It adapted.

Her hallucinations were not random. They were encrypted fragments of trauma, full of memory and symbolic logic (Moskowitz et al., 2009; Van der Hart et al., 2006). Once she began to decode them, they lost some of their threat.

Reframing came before resistance. We did not begin by arguing with delusions. We began by offering context—psychological, symbolic, and clinical. Meaning reduced fear. Insight reduced shame.

Imagery came before words. Her psyche spoke in symbols long before it spoke in narrative (Ogden et al., 2006; Schore, 2012). Much of the early work was about staying with the image until language caught up.

The process only stabilized after the trauma was named in full. Until then, it kept shifting. Once it had words, it had shape. And once it had shape, she could relate to it.

This work suggests that trauma, psychosis, and symbolic content are not separate domains (Lysaker et al., 2010). They speak to each other. But only when someone is willing to listen.

16. Conclusion

Luna's healing was nonlinear. Her trajectory moved in waves, hope, collapse, return. It required flexibility, patience, and precision.

She did not walk out of prison cured. But she walked out transformed. She was no longer a container for other people's shame.

Her trauma had a shape. She had the language to name it, at least for a time.

Author's Note

Although this case may appear to reflect a resolution of schizophrenia through therapy and medication, the outcome likely depended on several key factors. The client was unusually agreeable and psychologically minded, and the structured, contained prison setting allowed for consistent therapeutic contact over a multi-year period. These conditions are not typical in outpatient settings and likely played a role in the stability she achieved.

It is also important to note that each time one cluster of symptoms resolved, another often emerged in its place. This pattern may have continued after our work ended. I was not able to follow up

with Luna following her release. However, at the time of termination, I believed she had developed enough insight and psychological resilience to manage future challenges independently.

Schizophrenia remains one of the most difficult psychiatric diagnoses to treat. In this case, a combination of therapeutic alliance, symbolic reframing, and medication appeared to support long-term symptom management within a highly structured environment.

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