INTERPRETATION OF SCHIZOPHRENIA

Fourth Period: The Psychosis

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I
The Onset

In most cases only one solution, one defense, is available to the psyche that has undergone the inner and outer assaults described in the previous chapters: to dissolve the secondary process, the process that has brought about conceptual disaster and has acquired ominous resonance with the archaic primary process. It is at this point that the fourth, psychotic, period begins. It covers the whole psychosis, from its onset to termination. I divide this period into four stages, which will be described in Part Four. In this chapter the discussion will be limited to the initial stage of the psychosis, which is the most important from a psychodynamic point of view. We shall examine in detail the psychodynamic significance of the acute paranoid attack, which lends itself more to a didactical presentation. We must keep in mind, however, that the psychosis may assume many different forms. Also, the prepsychotic panic and the psychosis may blend gradually and

slowly, by almost imperceptible steps. At times the gradual changes are so minimal that neither the patient nor his relatives are aware of them. An acquaintance, however, who has not seen the patient for a long time generally recognizes the transformation at once.

When the secondary process starts to disintegrate, it loses control of the primary process, which becomes prominent. The patient acquires nonleamed, nonimitated habits that will constitute his schizophrenic ways of dealing with the world and himself. They are archaic and to a large extent unpredictable ways. They have the flavor of myths and primitivity. They finally do change the unbearable concepts into hallucinated lions and tigers, and mother and father into persecutors or kings or fairies. In other words, the individual now evaluates some aspects of the external world and reassesses some of his past experiences in accordance with the modes of the primary process. The formal characteristics of the dissolution of the secondary process and the return of the primary process will be studied in Part Three.

During the prepsychotic panic, the patient had, so to say, protected the world from blame and to a large extent had considered

himself responsible for his own defeat. Now he externalizes again this feeling. He senses a vague feeling of hostility almost in the air. The world is terrible. A sensation of threat surrounds him. He cannot escape from it.

The psychosis starts not only when these concept-feelings are projected to the external world, but also when they become specific and concrete. The indefinite feelings become finite, the imperceptible becomes perceptible, the vague menace is transformed into a specific threat. It is no longer the whole horrible world that is against the patient; “they” are against him. No longer has he a feeling of being under scrutiny, under the eyes of the world; no longer a mild sense of suspiciousness toward his unfriendly neighbors. The sense of suspiciousness becomes the conviction that “they” follow, watch, influence, or even control him. The conceptual and abstract are reduced to the concrete, the specific (Chapterl5). The “they” is a concretization of external threats; later, “they” are more definitely recognized as FBI agents, neighbors, or other specific persecutors. Whereas often during the third period the patient felt that millions of authorities were justified in having the lowest opinion of him, now he feels that a few malevolent, powerful people are unfair toward him

and cause him troubles. There is thus a return to a situation similar to the one he experienced in his childhood, when he felt that a few powerful people were responsible for his difficulties; but now there is a displacement in his attributing the responsibility. In the majority of cases, not the parents but other people are considered the wrongdoers. This displacement permits, even during the psychosis, a partial repression of the bad image of the parent. In many cases the displacement is later extended to a whole category of persons who are identified with the original wrongdoers. But whether a whole category of people, or a few persons, or only an individual, is seen as the persecutor or persecutors, such people are experienced as persons, as malevolent Thou or malevolent you. The malevolent you, who had been transformed, introjected, tamed, and transformed into a distressing other, is now extrojected, projected, appears strong, often in the most unusual, fantasied forms. At times the patient refers not to a person as the persecutor, but to a machine, rays, telepathy, electricity, with the tacit or manifest understanding that these means are used by some malevolent human beings.

The patient often experiences some phenomena that convince him that something is done or ordained against him. He is the victim of

a plot. He is accused of being a spy, a murderer, a traitor, a homosexual. He hears hallucinatory voices that repeat these accusations. He is unhappy, fearful, often indignant.

At first impression one would think that the development of these symptoms is not a defensive maneuver at all. The patient is indeed suffering. It is not difficult to recognize, however, that the externalization (or projection) and the reduction (or concretization) of some of the psychodynamic conflicts into these psychotic symptoms prove to be advantageous to him. As unpleasant as it is to be accused by others, it is not as unpleasant as to accuse oneself. It is true that because of the cognitive transformations, to be studied in Chapter 16, the accusation assumes a specific form. For instance, the projected feeling of being a failure does not appear as a belief of being accused of being a failure, but of being a spy or a murderer. These accusations seem worse than the original self-accusations, but are more easily projected to others. The patient who believes he is accused feels falsely accused. Thus, although the projected accusation is painful, it is not injurious to the self-esteem. On the contrary, in comparison with his prepsychotic state, the patient experiences a rise in self-esteem, often accompanied by a feeling of martyrdom. The person who is

really accused now is not the patient, but the persecutor who is accused of persecuting the patient. What was an intrapsychic evaluation of the self now becomes an evaluation or an attitude of malevolent others who reside in the external world. No longer does the patient consider himself bad; the others unfairly think he is bad. The danger, which used to be an internal one, is now transformed by the psychosis into an external one. *In this transformation actually lies the psychodynamic significance of the paranoid psychosis.* Guilt feeling is eliminated. In some cases pleasant self-images that were not allowed to exist are now recaptured and often assume a grandiose, distorted, grotesque appearance.

The delusion of persecution is not just a projection and a concretization. An unpleasant part of the self-image is restituted, brought back to symbolic equivalents of the people who originally appraised the patient in a way that, rightly or wrongly, was experienced as destructive and undermining. Inasmuch as this appraisal was experienced in this negative way, it became an important constituent of the negative self-image. In the psychotic period the rest of the self no longer accepts that part of the self-image.

An incomplete form of this mechanism is found in some neurotic, borderline, prepsychotic, and also psychotic patients. In these cases the patient continues to accuse, hate, and disparage himself at the same time that he thinks that other people have the same feelings toward him. Thus, there is a partial projection to other people of the feelings that the patient nourishes toward himself, but there is no repudiation of this self-accusatory component of his psyche, that is, of the self-image of the bad child. In these instances the mechanism of projection, which is arrested before it reaches full proportions, consists of the fact that people in general are experienced as authorities and are identified with the parents. It does not consist of a return to others of the derogatory self-image. In some of these cases the emotional disturbance to which the patient is subjected is terrific. The *you* is experienced both outside, in the external world, and inside, in the psyche of the patient. If the emotional pressure continues or increases, the patient may find relief only in a psychotic attack, which will remove *the internal you,* that is, the unpleasant image of the self.

In some cases the transition between the third and fourth period is not so clear or definite as we have described. Frosch (1964) has illustrated a lifelong psychotic character without definite psychosis,

and, as we have already mentioned, Hoch and Polatin (1949) reported cases with a permanent pseudoneurotic symptomatology. At times the sequence of events takes an insidious, slow course that is hard to delineate. We really do not know when the psychosis started. These are the cases that received most attention from Adolph Meyer, who saw the process as an indefinite deterioration of habits (see Chapter 2). At other times we do not have definite psychotic symptoms, but only oddity of behavior reminiscent of what Bleuler called latent schizophrenia (Chapter 2). In some cases the patient (more frequently a woman) presents a symptomatology that is halfway between a phobic psychoneurosis and a delusional psychosis. The patient has several fears, fo instance, of being attacked at night. Somebody may come while she sleeps and strangle her or kill her in various ways. Psychodynamic studies soon reveal that these fears are concrete representations of the more complicated fear of life that the patient is experiencing.

Since the first edition of this book was published in 1955, we have witnessed in the United States a marked increase in cases of schizophrenia occurring in adolescence and early adulthood, from the age of 13 to 23. In contrast to previous decades, psychiatric hospitals

have recently admitted a large number of young patients. We must assume that the present cultural climate in the United States facilitates the occurrence at an early age of that conceptual attack to the self that brings about resonance and unification with primary process experience. To follow the sociologist Riesman (et al., 1950), the culture has recently become more and more other-directed. The models are the peers and the contemporaries, not the older generations or the heroes of the past. The conceived ideals are considered less distant and are expected to be more quickly attained. Consequently, the despair in the self occurs earlier in life.

This consideration and others reveal that there is a strict relation between the psychodynamics of the individual case and the sociocultural environment. The events that we have described in this chapter, as well as in Chapters 5, 6, and 7, are either facilitated or inhibited by sets of sociocultural circumstances that will be studied in detail in Part Six.

II
Different Views of the Psychodynamic Meaning of the Psychosis

Some psychiatrists interpret the psychosis, not as a negative or pathological phenomenon, but as a positive development that reveals truths to fellow men and opens new paths toward greater moral values. We must devote a few words to these conceptions, which recently have acquired some popularity. In several writings, the Finnish psychiatrist Siirala (1961, 1963) discusses what he considers the prophetic value of many apparent delusions of schizophrenics. Siirala sees the patient as a victim and as a prophet to whom nobody listens. He sees the therapist as a person who has the duty to reveal to society the prophecies of these patients. These prophecies would consist of insights into our collective sickness, into the murders that we have committed for many generations and that we have buried so that they will not be noticed (1963). He feels that schizophrenia emerges out of a common sort of sickness, a sickness shared by the others, the healthy.

In Laing's opinion schizophrenia is not a disease, but a broken-down relationship (1967). The environment of the patient is so bad that he has to invent special strategies in order "to live in this unlivable situation." The psychotic does not want to do any more denying. He unmasks himself; he unmasks the others. The psychosis

thus appears as madness only to ordinary human beings, who have the limited vision of the secondary process. Not only the family but society at large with its hypocrisies makes the situation unlivable. Echoing in a certain way Szasz (1961), Laing goes to the extent of saying that the diagnosis of schizophrenia is political, not medical.

I agree with these authors only to a limited degree. In my opinion, the schizophrenic, especially the paranoid, in both his prepsychotic and psychotic stages, behaves and thinks as if he had a psychological radar that enabled him to detect and register the world's hostility much more than can the average person. Must we assess this characteristic as a positive value that we can share or as manifestation of illness? To discuss whether the paranoid is delusional or a prophet is like discussing whether a dream represents irrationality or the "real reality." The dream is very true as an experience and may indeed reveal a message that is not easily heard when we are awake, but dreams transmit the truth in a fictitious way. Although hostility exists in the world, the psychotic's version of it is pathological. Although the hostility is related etiologically to the psychosis, other predisposing factors also enable it to become related. Although the hostility is an operating psychodynamic factor, other important psychodynamic

factors are involved.

We must be aware of the possibility that the patient has positive values upon which the psychosis inflicts a transformation. If we remove the delusional overlay we may retrieve the values in their original purity. In our psychodynamic inquiries we discover that the patient was exposed to hostility in his family. Moreover, as we shall see in Part Six, studies of social psychiatry reveal that the parents, too, were the object of adverse social circumstances that predisposed them to poor parenthood. However, in my opinion we cannot conclude that the schizophrenic psychosis is a normal reaction to an abnormal situation, as the mentioned authors imply. In my opinion it is *an abnormal way of dealing with an unfavorable situation.* The psychosis cannot be called just a rebellion to a prior unlivable situation. The prior situation may have been so unfavorable as to be experienced as unlivable, but the rebellion is abnormal and also hardly livable. In other words, we must not stop at an analysis of the environment that the patient met, especially in childhood. This is number one in our list of inquiries, but only number one. We must also study the particular way in which the future patient experienced the environment, the particular ways by which he internalized it, and the particular ways by

which this internalization led to subsequent instability and finally to the psychosis.

It is true that schizophrenia reflects sociocultural factors in many respects. It is also true that from the study of it we may learn new values. The same statement, however, could be repeated for every human situation that is not strictly biological. For instance, if we analyze a murder that has been committed, we soon discover that the whole cause of it is not restricted to the murderer's intent, but that society, too, shares some responsibility, Moreover, paraphrasing Siirala, we may say that not only our present society is responsible, but all previous generations of men who directly or indirectly have influenced our lives so that murders are possible in our time. In the same way, each case of schizophrenia is representative of those human situations in which something went very wrong in the act of becoming part of society or in the act of consensually validating one's emotions, behavior, and symbols with those of one's community.

However, this is different from assuming that the schizophrenic is directly concerned with the sickness of society or that the sickness of society is directly or solely responsible for the schizophrenic

syndrome.[1] Although the paranoid schizophrenic may borrow the scenario of the society-oriented person, his suffering can easily be recognized as a personal one and as different from that of the philosopher, the prophet, the innovator, the revolutionary, the dissenter.

Contrary to Laing's conceptions, in by far the majority of cases we cannot consider the patient in his predominant characteristics as an asserter of truth, a remover of the masks. The patient tells us his experiential truth, which often contains some truth about the evils of the world. This partial truth must be recognized by the therapist and must be acknowledged and used in treatment (see Part Seven). Its import must be neither ignored nor exaggerated. If we ignore it, we become deaf to a profound message that the patient may try to convey. If we exaggerate it, we also do a disservice to him. We may admire the patient for removing the masks, for saying what other people do not dare to say, for how much he accepted and how much he rejected, for the supreme effort to adjust to a nonadjustable situation, and for going down to defeat rather than to deny his self.[2] But we must also recognize that the fragments of truth he uncovers assume grotesque forms, and that he will apply these grotesque forms to the whole

world, so that whatever insight he has achieved will be less pronounced and less profound than his distortion. And his distortion not only has no adaptational value, but is inimical to any form of adaptation even within a liberal community of men.

The psychotic outcome is thus only a pseudosolution. Therapists and patients alike must come to the recognition that the environmental circumstances are responsible for the disorder, not in a simple relation of direct causality, but because in different stages of the patient's development they facilitated intrapsychic mechanisms that later permitted the psychosis to feed on itself. It is too simple and too naive to join the patient in blaming solely the environment. The psychosis does not represent any longer an external drama; it is predominantly an inner drama and inner metamorphosis. As a matter of fact the main defensive aspect of the psychosis is the transformation of an intrapsychic danger into an external one.

Another view of the psychodynamic meaning of the psychosis is that the psychosis merely represents irrationality directly transmitted from the parents to the patient. This point of view, which we have already referred to in Chapter 5, was presented in 1958 by Lidz and

collaborators. It was later expressed again by Fleck (1960), Wynne and Singer (1963), and Jackson (1967a,*b).* This irrationality is said to be learned by the patient in a way similar to the way a child leams special habits or some patterns of living from his parents. Here are some examples.

Fleck (1960) described a patient, Dollfuss, who presented bizarre and peculiar psychotic behavior, delusions, ideas of reference, and hoarding of food. Like his father he was preoccupied with strange mystical religions and would seclude himself for hours in the bathroom as his father had also done.

D. D. Jackson (1967a) reported the following example. A young paranoid patient says very little except for the following sentence, which he often repeats: "It's all a matter of chemistry and physics." The interviewer asked the parents what they thought about their son's illness. After a long silence the mother said, "Well, we don't know anything about it. It's just a matter of chemistry and physics to us." The father and the patient then repeated in a low tone, "Yeah, just a matter of chemistry and physics." But to think that schizophrenia is a "matter of chemistry and physics" is not necessarily schizophrenia irrationally

transmitted from parents to children. Even a large number of psychiatrists share this belief. Wynne and collaborators go even further than Lidz and Fleck. They believe that not only irrational content but even an abnormal way of thinking is learned by the patient from the members of the family. The patient has learned to think in a diffuse, fragmented, or amorphous way.

I understand how easy it is to be persuaded by this interpretation. A female patient hears a voice calling her a prostitute. But we know from her history that the mother would really call her "a whore' ' just because she was wearing lipstick.

The mother of a young paranoid male schizophrenic may be a hostile, suspicious person, whose vision of the world is one permeated by pessimism, distrust, and hate: the world is a jungle; people are ready to cheat you. If you want to survive, you must be careful and be prepared to defend yourself. This point of view is not necessarily psychotic. It may even be called a philosophy of life, which may very well be transmitted to the world. However, when the son of this mother not only sees the world as hostile, but starts to think that people are plotting to kidnap him or to poison him, he goes further

than the mother. To the irrationality of the mother he has added his psychotic, autistic, primary process twist.

The error some authors make is *not* simply in seeing a connection between the irrationality of the patient and that of his parents. *Obviously such connection exists.* These authors err when they confuse psychodynamics (or content) with the form (psychological structure). The irrationality of the schizophrenic is not transmitted from generation to generation by means of simple mechanisms, in the way that language, manners, or mores are transmitted. Direct transmission is not a mechanism that can explain the characteristics of schizophrenic thinking, delusional ideas, hallucinations, and so on. If the parents of the schizophrenic would present the same irrationality and would use the same forms of cognition as the patient, they themselves would be recognized as schizophrenics, but they are not, except in a relatively small percentage of cases. They may be peculiar, odd, eccentric. Certainly their children may adopt their peculiarities, but they are not to be diagnosed schizophrenic simply because they learn these peculiarities. To the extent that they do, they may also be eccentric, but not schizophrenic. Schizophrenia is not learned, although it may be acquired by virtue of certain relations with parents

and the family. The family affects the patient psychodynamically, so that eventually under the stress of conflicts the secondary process mechanisms weaken or disintegrate, primary process mechanisms acquire predominance, become the media that carry the conflicts, and the psychosis occurs. Certainly psychotic symptoms reflect or echo the family conflicts, just as a dream may reflect family conflicts. Family conflicts could never explain the characteristics of dreams, for example, reduction of ideas to visual images, special way of thinking, confusion of reality with imagination, and so on.

In one of the just mentioned examples, the mark of schizophrenia was not that the patient had been told by the mother that she behaved like a prostitute: this may be part of the dynamics. The mark of schizophrenia was that the mother's accusation in this case (and not in that of other patients with similar history) was transformed into a hallucinatory voice.

Not only the family, but also society and culture may inflict on the individual peculiar habits, false beliefs, myths, prejudices, and schizophrenic-like modes of thinking. To the extent that the individual learns these peculiarities from the culture and even accepts them as

normal and rational, he is not psychotic. He becomes a concern to the sociologist and anthropologist as well as to the psychiatrist.

Culture and society, like the family, remain important psychodynamic factors because they do affect the psychodynamics of the family and of the sense of self. Thus indirectly they may contribute greatly to the engendering of mental illness (see Part Six). It is because I have seen how many times these issues have been misunderstood that I have thought it necessary to devote to them more than a few words.

Needless to say, the misunderstanding of how the familial or social environment affects the patient does not detract from the high value of the contributions to the study of the psychodynamics of the family of the schizophrenic that such authors as Lidz, Jackson, Wynne, Fleck, and others have made.

A point of view that, in some respects, seems opposite to the one just considered must also be avoided, namely, the view that family relations operate only by triggering off potential psychotic symptoms in genetically predisposed individuals. Again the mechanisms are not

so simple. Disturbed family relations are not just predisposing or precipitating factors. They become intensely connected with the personality and psychological structure of the individual patient. They are intertwined with the development and psychotic denouement. They do not act just as cold weather does in reference to pneumonia and malnutrition in the case of tuberculosis. The interplay is much more complex.

III
Relevance of Late Precipitating Events

For the sake of clarity we have omitted from our discussion the importance of some external events that have occurred shortly before the prepsychotic panic or the onset of the psychosis.

The importance of these events deserves careful study. There are many cases of schizophrenia in which the prepsychotic panic or the onset of the psychosis occurs without having been preceded by any particularly significant external event. On the other hand, other cases occur after such events as marriage, childbirth, loss of a position, accident at work, automobile accident, traveling, flunking examinations, striking of a new friendship, quarrel with one's boss or

with coworkers, changing apartment, and so on.

In the majority of these cases it is easy to recognize that the precipitating event would not have had the power to engender the state of panic and the psychosis if the ground had not been prepared by the circumstances that we have described in Chapters 5, 6, and 7.

However, we cannot dismiss altogether the significance of the precipitating event. Here again we have another manifestation of the interplay between two categories of factors: the external and the internal. The authors who divide schizophrenia into the process and reactive types acknowledge the importance of the precipitating event only in the reactive type.

Let us examine now some of these precipitating events. In most cases it is easy to recognize that the occurrence of a specific event suddenly put the patient in a position in which he had to face a challenge that he thought he would not be able to cope with. Even the very schizoid person at times is not able to avoid challenges. As we have mentioned before, in spite of his detachment he harbors secret desires of experiencing feelings again and of making excursions into

life. Occasionally, in a rather uncautious manner, he takes active steps that are completely incongruous with his previous attitude. More often, however, he lets himself be pushed by the events.

A schizoid young woman may be induced by her mother to get married, although she is psychologically unprepared for that step. The husband, actually selected by the mother, may be experienced as another parent who will evoke the old childhood anxiety.

A schizoid man, who has lived in a single room of a boardinghouse for many years, practically in isolation, may come in contact with another tenant, an aggressive, domineering woman. By her aggressive methods, she may succeed in overcoming his shyness, and then later in convincing him to marry her. Sexual urges or desire to comply with the expectations of society may induce the patient to accept the marriage proposal. After the marriage, the patient's anxiety is apt to increase because he finds in the wife a replica of the image he once had of his parents. He will make serious attempts to adjust to the spouse's new way of living, but he will find that task insurmountable. Because of what he considers blatant proof of his failure in living, he can no longer hide from himself the feeling of worthlessness that he

has been able to check up to that point in life.

The intimacy of marriage is often very threatening for the patient, because it tends to reproduce situations similar to those that have caused him intense anxiety in his childhood.

Another frequent occurrence that may precipitate the panic is the unexpected development of a friendship or of some social contact with a person of the same sex. Strangely enough, the patient succeeds, for the first time in his life, in establishing a more meaningful interpersonal relationship, but homosexuality, which had been repressed for so long on account of the social ostracism connected with it and on account of the patient's rejection of the parent of the same sex, threatens to come to the fore again and causes deep anxiety. This development is often referred to in the literature as homosexual panic. Disappointments in love may be especially traumatic in those women (now diminishing in number) who seek their identity only by living for a man, or in marriage. The security of a love relation compensates for the instability that permeates their lives. The challenge here is how to be able to face life again after such disappointment. The challenge constituted by childbirth will be

discussed in detail in Chapter 13. Acute catatonic attacks are often precipitated by sudden and difficult decisions the patient has to make (Chapter 10).

The person with a stormy personality will be forced even more than the schizoid to face the challenges of his inappropriate actions, which bring about additional precipitating events.

In a large number of cases the event seems so minor as to be hardly conceived as the precipitating event of such a serious occurrence as the psychosis. For instance, the patient had a minor automobile accident, lost her pocketbook, changed his apartment, has been dismissed from a very insignificant job. In these cases we must be aware of two possibilities: (1) the apparently insignificant event has the power to reactivate a very significant and traumatic event in the early life of the patient (see case of Laura, Chapter 11; (2) although not related to specific past events, the episode transcends itself in psychological significance; *it fits the patient's particular vulnerability.* For instance, a small accident on the job may be interpreted as the final proof of the patient's utter inadequacy. In other words, to the distressing reality of the event, in itself not overwhelming, additional

traumatic force is added symbolically. And it is the symbolic part that is overwhelming.

We are often confronted with an opposite set of factors. Very extenuating and taxing external or realistic events not only do not precipitate a schizophrenic psychosis, but at times seem even able to prevent it. Conditions of obvious danger, as they occur in time of war, national defeat, and adversities that affect the whole community, do not *per se* precipitate schizophrenia. They may elicit anxiety and psychological disorders, but do not necessarily hurt the sense of self. In some conditions, like state of war or military defeat, a feeling of solidarity or common destiny and the absence of personal responsibility for what is happening may even be helpful to the self-image.

The psychiatrist must carefully differentiate two types of anxiety, the one that signals an external danger and the one that signals an internal one. Only the latter is important in the psychodynamics of schizophrenia. As a matter of fact we have seen that one of the important psychodynamic aspects of the psychosis is that of transforming an inner danger into an external one. This

transformation occurs also in many dreams, but not in all of them. The dream, more than the psychosis, accepts injury to the self. It may even "train" the dreamer to accept the danger or to find ways to solve it (see Chapter 39).

Notes

[1] This point of view is related to what some philosophers call the theory of "internal relations." According to this view, "The world is rational in the specific sense that every fact and event is connected with its context, and ultimately with every other fact and event, in a way that is logically necessary" (Blanshard, 1967). For instance, the fact that Richard Nixon is president of the United States is connected with the fact that Columbus discovered America and that the United States is part of our solar system.

Unless we adopt in psychiatry, too, the theory of internal relations, we must consider and evaluate only the factors that are necessary, nonreplaceable, and specific determinants of the phenomena that we are studying.

[2] See, for instance, the case of Geraldine (Chapter 40) and. to a lesser degree, the case of Gabriel (Chapter 9).

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