The Break with Reality

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The Break with Reality

In Part Two we have studied the psychogenic factors that lead to a schizophrenic disorder. We have seen how an extreme state of anxiety, originating in early childhood, produces a vulnerability that in many instances lasts for the whole life of the individual. We have seen how desperately, even heroically, the patient attempts to maintain contact with reality, to survive, and to grow. However, in dealing with new threats in adolescence and adult life, his defenses become increasingly inadequate. Confronted with overpowering anxiety, the patient finally succumbs, and the break with reality occurs. In other words, when he cannot change the unbearable vision of himself any longer, not even in prepsychotic ways, he has to change reality. But reality cannot change, and he has to change himself again in order to see "reality" in a different way.

In this part of the book we shall examine the mechanisms with which the patient attempts to envision life in a less frightening manner. He will enter the world of schizophrenia. The psychotic transformation will enable him to experience himself and the

environment in strange, unique ways, often not susceptible to consensual validation. And yet the mechanisms that he resorts to now are available to every human being; they are part of his human nature. As a matter of fact, even normal people use some of these mechanisms when they make errors, especially in conceptual formation or in the understanding of concepts. However, what is an exceptional error for a normal person may not be an error for the schizophrenic but a way of thinking which guides his life. All this implies that the mechanisms by which the patient experiences reality and himself in a different way are predominantly cognitive mechanisms.

In Part Two we have seen that psychodynamic studies are chiefly concerned with the emotional life of the patient. At a human level, however, only the most primitive emotions do not depend on cognition, although they too become interconnected with cognitive processes (see Chapter 7 of this book; also Arieti, 1967, 1973). The cognitive process may be unconscious, automatic, or distorted, but it is always present. As it is true that no human activity is completely deprived of emotions, because emotions accompany us everywhere and to a great extent determine our lives, it is equally true that there are no naked emotions—emotions are always accompanied by some

kind of cognitive process. By cognitive process is meant some kind of organized mental activity, by virtue of which an understanding of the situation involved is attempted. Emotions, however, have the power to distort the cognitive processes, just as cognitive processes distort old or create new emotions (Arieti, 1967). The most pronounced distortions occur in schizophrenia.

In neuroses the distortion occurs to a much lesser degree. But more important than the degree of the distortion is the recognition that such distortion occurs. In the neuroses such recognition on the part of the patient exists, or if it does not exist, it may relatively easily gain consciousness through psychotherapy. It is not so in schizophrenia. Let us take, for example, the case of an obsessive patient who has the obsession that if he does not wash his hands three times at each meal, his children are going to become sick and will die. This patient fully recognizes the absurdity of such an idea. It is true that a power stronger than himself will continue to compel him to wash his hands three times, but he has retained sufficient logical power to recognize the unreal nature of such an obsession. Usual psychoanalytic therapy will help in explaining what unconscious emotional factors have determined this symptom. Instead, in the case

of a deluded schizophrenic patient, who thinks that he is the king of Egypt, let us say, usual analytic procedure may also uncover the unconscious emotional factors that have determined this delusional idea. It will not explain, however, why such an idea is accepted as reality by the patient, in spite of the most complete contradictory evidence. In other words, it does not explain what change has occurred in the cognitive powers of the patient to make him no longer able to test reality. To limit ourselves to saying that "the ego of the schizophrenic is weak and disintegrating under the stress of the emotions" is to cover the complexity of the problem with a semantic screen. We must make an effort to understand why the disintegration has that particular aspect, why it deprives the patient of the power to test reality. [1]

General Views of Schizophrenic Cognition

Several interpretations have been proposed. The simplest and probably the most naive is the hypothesis that there are two types of thinking, rational and irrational, and that the schizophrenic adopts the irrational.

This point of view has not been subjected to scientific analysis. First of all, any "irrationality" is not whimsical or completely at random, but retains some organization and direction. Even mechanisms conducive to error can be understood. Secondly, this hypothesis does not explain how the schizophrenic can accept irrationality in spite of contradictory evidence. How can he believe that he is the king of Egypt? Obviously he can believe so because he is irrational. But this is a pseudoexplanation that attempts to explain in terms of what has to be explained.

A second interpretation is that offered by Goldstein (1939, 1943a). According to this author, whereas the normal human being has two attitudes toward the world, the abstract and the concrete, the schizophrenic has only or predominantly the concrete.

These two attitudes, according to Goldstein, are not acquired, but *a priori;* that is, they are inherent in human nature. They are two ways of adapting to the world. When he is in a concrete attitude, the individual is bound to the immediate experience or to the specific stimuli to which he is presently exposed. In the abstract attitude, man transcends what is specific, immediate, particular. He is oriented

toward a category, a class, a general meaning, and detaches himself (that is, *abstracts* himself) from the given experience.

According to Goldstein, the abstract attitude is basic for the following abilities: (1) to assume a mental set (frame of reference) voluntarily; (2) to shift voluntarily from one aspect of the situation to another; (3) to keep in mind simultaneously various aspects; (4) to grasp the essential of a given whole and to break up a given whole into parts and to isolate these parts; (5) to generalize—that is, to abstract common properties; (6) to detach the ego from the external world.

We owe a great deal to Goldstein, because he has opened a new path of fruitful inquiry. There is no doubt that in many instances schizophrenics characterize themselves by being specific, concrete, and unable to transcend the particular situation or set. We must recognize, nevertheless, that Goldstein's formulations are incomplete and suffer from the fact that originally he worked only with braininjured patients. Life, experienced only or predominantly at a concrete level, is a reduced life, but not necessarily a psychotic one, or a life that has sustained a psychotic loss of reality. A brain-injured patient with cortical lesions may not be able to understand difficult mathematical

or philosophical problems, but he may remain in the realm of a limited reality. Goldstein himself states that the concrete attitude is a realistic attitude. Even a subhuman animal, which does not possess the ability to conceive categories, concepts, or platonic universals, lives in a limited, but nevertheless realistic, world. Goldstein too realizes that the concreteness of the schizophrenic is not the same as that of the brain-injured patient, but he interprets the difference simply as the result of different levels of concreteness. This explanation is not satisfactory. We find different degrees of concreteness in various organic defects and also in mental deficiencies, but these conditions are not necessarily accompanied by psychosis. As a matter of fact, the organic defect, although limiting greatly human potentialities, may eliminate the psychoses, as, for instance, in some forms of psychosurgery. In the adoption of the concrete attitude Goldstein does not recognize psychodynamic factors that have a compensatory purpose or a symbolic meaning. The only purpose Goldstein recognizes is that of avoiding a decompensation, or what he called "the catastrophic situation" that he described in patients suffering from organic brain injuries. Although Goldstein was very much influenced by Jackson and by Vigotsky, he did not accept the developmental

approach of these two authors.

In my opinion the phenomena studied by Goldstein in schizophrenia do not represent a reduction of the psyche to a concrete level, but a process of active concretization. By active concretization I mean that the psyche is still capable of conceiving the abstract, but not of sustaining it because the abstract is too anxiety provoking or too disintegrating. We must remember that abstract ideations are not lost by the schizophrenic. If they were lost, the patient would not have schizophrenogenic anxiety. The abstract ideations, however, are transformed by the psychotic into concrete representations. For instance, a paranoid had the delusion that his wife was putting poison in his food. He actually felt that his wife disturbed, spoiled, "poisoned" his life. Thus the abstract poisoning became a concrete and specific one; a concept was transformed into an object, a chemical poison, after the inner turmoil had been projected to the external world.

We may actually interpret the whole schizophrenic cognitive transformation from a general point of view as a process of active concretization. However, the reader must realize that this explanation is not complete. We must determine and study the different modalities

by which this active concretization takes place.

Another group of authors interprets schizophrenic cognition as characterized by dedifferentiation (that is, loss of distinction of parts within any system) or regression (that is, return to earlier and less mature functioning or behavior). It is easy to recognize the affinity between the concepts of concretization, dedifferentiation, and regression. Ultimately all the psychiatric theories postulating regression (or similar concepts) are derivatives of Darwin's theories, through the intermediary concept of dissolution advanced by the I. Hughlings Iackson (1932).Regression neurologist dedifferentiation are often considered as development or evolution in reverse: the direction is from higher to lower levels of integration.

According to Jackson's principle, in neurological and mental diseases the functions that are the last to develop are the first to be lost. In every disease we have two kinds of symptoms: (1) negative: the loss of high functions (in Goldstein's theory, loss of abstract attitude); (2) positive: the emergence of supremacy of the functions of the level that remains intact (in Goldstein's theory, the concrete attitude).

Freud too was influenced by Jackson in postulating the concept of regression. In schizophrenia the libido would revert to the narcissistic stage (see Chapter 2).

As we shall see several times in this book, an author who has inspired many psychiatrists, including myself, is the psychologist Heinz Werner, with his comparative developmental approach. According to Werner, in psychopathological conditions cognitive structures that are characteristic of previous stages of development emerge. Development means unfolding in time of forms or structures. Three types of development can be distinguished. The first is the phylogenetic, or the unfolding of a psychological mechanism or form through the evolution of the species. The second is the ontogenetic, or the unfolding of a mechanism or form through the maturation of the individual. The third is the microgenetic. Because this type is less known than the previous two, some words of explanation are required.

Microgeny, as illustrated by Werner (1956), is the immediate unfolding of a phenomenon, that is, the sequence of the necessary steps inherent in the occurrence of a psychological process. For

instance, to the question, "Who is the author of Hamlet?" a person answers "Shakespeare." He is aware only of the question (stimulus) and of his answer (conscious response), but not of the numerous steps that in a remarkably short time led him to give the correct answer. Why did he not reply, "Sophocles" or "George Bernard Shaw"? How did he reach the correct answer? There are numerous proofs that the answer was not necessarily an established and purely physical or neuronic association between *Hamlet* and Shakespeare, but that an actual unconscious search went on. In fact, if the same question is asked of a mental patient (either affected by cerebral arteriosclerosis or by schizophrenia in a stage of advanced regression) or of a person who is very sleepy or drunk or paying little attention, he may reply, "Sophocles" or "George Bernard Shaw." These are wrong but not haphazard answers, inasmuch as they refer to playwrights. The mental search required by the answer had at least reached the category of playwrights. The numerous steps that a mental process goes through constitute its microgenetic development (Arieti, 1962c).

These three types of development—phylogeny, ontogeny, and microgeny— unfold in time, although with great variation in the quantity of time. The length of this span of time ranges from periods as

long as geological eras in the case of phylogeny to periods as short as fractions of a second in microgeny. What is of fundamental importance is that the three processes tend to use the same structural developmental plans. We do not mean literally that microgeny recapitulates ontogeny and that ontogeny recapitulates phylogeny, but that there are certain formal similarities in the three fields of development and that we are able to individualize schemes of highest forms of generality that involve all levels of the psyche in its three types of development. It is equally important to recognize the variants of the same overall structural plans.

As I wrote elsewhere (Arieti, 1967), the two aspects of the psyche, the organization of forms (a logical order) and the threefold development (a temporal order) are equally important. Inasmuch as one tends to permanence, the other to change, a double functionality that constitutes a main characteristic of the psyche results.

Throughout this part of this book we shall illustrate how cognitive forms belonging to early stages of the three types of development reappear in schizophrenia.

There is finally another possibility that must be taken into consideration for the purpose of understanding schizophrenic cognition: namely, that the patient thinks in an abnormal way simply because he wishes to do so. This possibility may prove to be not as absurd as it may seem at first consideration, at least in some cases. Some patients, during the period of preschizophrenic panic, are able to evaluate in a conscious way what they consider the failure of their existence and to predict the unfulfillment of their life promises. The ways of thinking that in the past would occasionally emerge to consciousness and then be immediately rejected because they were unrealistic have now a very strong seductive appeal. The patients may choose to embrace them. Once they embrace these thoroughly, they can no longer dismiss them.

I believe that although this hypothesis cannot possibly explain the psychotic transformation, it may contain elements of truth. In some schizophrenics and preschizophrenics, and especially in incipient schizophrenics, there are periods during which the patient seems to understand both the world of reality and the world of psychosis and to be able potentially to choose between them. This possibility, as a matter of fact, will be stressed at a certain stage of

psychotherapy (see Chapter 37). We must still explain, however, why abnormal thinking is available and what kind of structure this abnormal thinking has.

The Principle of Progressive Teleologic Regression

I feel that schizophrenic cognition is not illogical or senseless, but that it can be interpreted. The schizophrenic patient adopts cognitive mechanisms that are different from those used by human beings generally. He does not think with ordinary logic, but follows different structural organizations that lead to deductions different from those usually reached by the healthy person. The schizophrenic is similar to a man who would solve mathematical problems, not with our decimal system, but with another hypothetical system, and would consequently reach different solutions. In other words, the schizophrenic interprets and consequently experiences the world in ways that differ from those of the normal man. In this part of this book we shall study the particular psychological structures that impose on a schizophrenic a psychotic existence. These structures, which are potentially available to every human being, become the prevalent ones

in the schizophrenic condition. Healthy persons do not ordinarily adopt these structures, except in dreams, in particular situations that will be described later, in occasional errors, and in some specific social and collective manifestations. This different faculty of experiencing and interpreting the world follows what Freud called the primary process (see Chapter 2). In reference to cognition, Freud restricted his study of the primary process to two essential mechanisms—displacement and condensation—which are described in Chapter 7 of his book *The Interpretation of Dreams* (1901). Later Freud connected the theory of the primary process to the libido theory and did not pursue the study of schizophrenic cognition.

Whether we accept the view that the schizophrenic adopts a concrete attitude or a less differentiated type of thinking or one that follows Freud's primary process or Werner's early phases of ontogenetic and microgenetic developments, the patient is almost unanimously recognized as using a less mature kind of cognition.

The characteristic of reverting to less mature mechanisms is a quite common occurrence in pathology. For instance, in diseases of the heart, when the sino-auricular node is injured, the more ancient

auriculo-ventricular bundle takes over its functions. This is as true in psychopathology as it is in general pathology.

Reverting to the use of less mature forms of development means what in psychoanalytic terminology is generally called regressing. Regression, a term introduced by Freud to indicate a return to earlier stages of libido (see Chapter 2), will be used in this book to indicate an unusual and intensified availability of psychological mechanisms and forms that are more typical of earlier developmental stages. [2]

As we have already mentioned, J. Hughlings Jackson's concept of neurologic dissolution, which is a precursor of the concept of regression, is too mechanistic and deterministic when applied to psychiatry. It does not help us to understand psychiatric conditions from a psychodynamic point of view. It does not indicate that regression (or its equivalents) has a psychodynamic meaning, a purpose.

I have tried to formulate the dynamic occurrence of the phenomenon of regression in the form of the following principle: if, in a situation of severe anxiety, function at a certain level of psychological integration cannot take place or does not bring about the desired results, a strong tendency exists toward functioning at lower levels of integration in order to effect those results (Arieti, 1955, 1967). I have called this the principle of teleologic regression. We must clarify that teleologic regression is not the only mechanism occurring in psychopathology, but one of many. However, because a special variety of it, more properly called *progressive teleologic regression*, plays such an important role in schizophrenia, we have to study it in detail.

First of all, we have to stress again that the anxiety that brings about regression in the pathology of schizophrenia is not just any type of strong anxiety, but the anxiety that, directly or indirectly, injures the self-image and is experienced as an inner danger (see Chapter 8). The strong anxiety apparently has the capacity to disintegrate the high levels of functioning, but the psyche does not cease to function; it reintegrates at lower levels.

The reader should note that the word *tendency* is used in the formulation of the principle of teleologic regression. In other words, this principle is not like a physical law, which must operate without exceptions. There is just a propensity toward its occurrence, but it may

not occur, as, for instance, in cases where something unexpected intervenes.

By resorting to lower levels of integration, the psyche turns again to methods that were discarded when new methods had been adopted. In one aspect (and *one* only) it is a repetition of history in reversed chronology. This happens not only to human beings, but to animals as well. Mowrer (1946) has demonstrated this principle in rats with a very ingenious experiment. The animals learned to protect themselves from an electric current by sitting on their hind legs. Later the rats learned a much better way; they discovered how to turn off the current by pressing a pedal. When this habit was well ingrained, it replaced the previous one. Later the pedal too was charged with electricity, and the rats had to face another shock if they continued to press it. At this point they went back to the method of sitting on their hind legs. Thus they reverted to the earlier and inferior method.

When experimental animals have learned to solve a problem with the mechanism of insight and, for some reason, can no longer solve the problem with this method, they revert to the method of trial and error. In other words, there is a tendency toward a reversed hierarchy of responses, from the highest to the lowest. The words regression and teleologic are used for the following reasons: regression, because less advanced levels of mental integration are used; teleologic, because this regression seems to have a purpose, namely, to avoid tension, stress, and anxiety by bringing about the wanted results. As a matter of fact, studies in abnormal psychology have revealed innumerable instances in which the mind in distress does not necessarily follow scientific thinking (events are the effects of previous causes), but rather teleologic thinking (events have a purpose). Thus, dreams, hallucinations, symptoms, delusions, and so on, seem to have a purpose, even though they themselves are the results of previous causes.

More often than not, of course, thinking that follows the principle of teleologic regression does not effect the desired results, but yet it will decrease the anxiety, at least temporarily. Legends and myths frequently reveal the adoption of this principle. For instance, the Jews, as described in the Bible, had reached that high cultural level that permitted them to worship an abstract God. When, however, they were under the stress of anxiety caused by the sudden disappearance of their leader, Moses, they reverted to the worship of the Golden Calf.

When Moses reappeared and the anxiety was relieved, they went back to the cult of the abstract God. Similar regressive tendencies have also occurred innumerable times in human history in special social situations. For instance, if diplomatic discussions do not bring about certain results, much more primitive methods, such as wars, paranoid attitudes toward minorities, and persecution of them, may be resorted to.

It is evident that in these conceptions we have a mixture of deterministic and teleologic explanations. Determinism is the all-embracing concept that has been adopted in science—causes determine effects. In teleologic explanation the fact or event that is being studied is seen as having a purpose, is envisioned as useful or agreeable to the individual, and it is because of its purpose that it occurs. The fact that a patient cannot function at a high level can be interpreted deterministically no matter whether the disturbance is organic or psychological in origin. The difficult fact to explain is how the psyche comes to use purposefully the lower-level mechanisms that are released and available again.

As I had opportunity to state in greater detail elsewhere (Arieti,

1967), since the work of Claude Bernard the usefulness or adaptational value of a pathological mechanism was recognized not only in psychiatric conditions, but in the whole field of medicine. In infectious diseases, for instance, fever occurs as a reaction to the invasion of foreign proteins. This reaction can be interpreted in accordance with deterministic causality. Fever, however, seems to have a purpose: to combat the invasion of foreign proteins. Here the organism seems to follow a purpose, or teleologic causality. Only organisms that are able to build up adequate defenses can survive and transmit such a possibility genetically. Thus the defenses, from a human point of view, do acquire a purpose.

We have already mentioned that in schizophrenia teleologic regression has distinctive features. First of all, it is determined by that special type of anxiety that we have described. Secondly, it is progressive. The term *progressive* here means that the regression does not tend to stop at a certain level, but proceeds to lower and lower levels unless treatment is instituted or unforeseeable fortunate turns of events occur. The situation is thus different from that occurring in other psychopathological conditions. For instance, the typical phobic patient, too, undergoes a regression. He may have a phobia that

prevents him from crossing streets, and this may stand for his abstract fear of life. He may become worse, and become afraid also of crossing squares, leaving his home, crossing bridges, and so on. The symptoms, however, remain phobias. Why regression should tend to proceed in untreated schizophrenia is a subject that will be discussed in Chapter 26. The progressive teleologic regression brings about the process of active concretization that we have described earlier in this chapter.

Notes

- The above concepts are expressed in the psychiatric literature at times with different terminology. Whereas in psychoneuroses the symptomatology is called dystonic, in schizophrenia it is called syntonic: that is, integrated with, or not denied by, the rest of the personality.
- [2] Bieber (1958) and Szalita (1958) have similarly criticized the Freudian concept of regression of libido. Bieber stressed that what we call regression is availability of generally unused mechanisms. For Szalita it means a lower level of functioning.
- Jackson's ideas today have undergone revisions (Livingston, 1962). The nervous system is no longer seen exclusively as a series of horizontally organized centers. In addition to the horizontal organization, there are vertical organizations between the different centers. The concept of interaction has been replaced by the concept of transaction: no longer linear or simple relations, but multiple relations between the different parts of the nervous system.
- [4] The emphasis here, however, is given not to the response in a behavioristic way, but to the central process that is responsible for the response.

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