# The First, or Initial, Stage

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#### The First, or Initial, Stage

#### I Introductory Remarks

In the previous parts of this book, schizophrenia has been examined in its manifest symptomatology, psychodynamics, and formal psychological structure. We shall now study the psychosis from the point of view of its progression, meaning progression toward regression. Of the four outcomes of schizophrenia (recovery, improvement,' arrest, regression), only regression will be considered here. Although Kraepelin himself gave great significance to the progress of the illness, to such a point that all his concepts about this condition were influenced by it, this progression itself has not been studied longitudinally.

The difficulty in studying schizophrenia from a longitudinal point of view is implicit in the long duration of the illness. Many psychiatrists focus their attention on the initial stages, which respond better to any type of treatment. On the other hand, psychiatrists

working in state hospitals do not see the prepsychotic or early psychotic stages. Even Meyer's longitudinal approach was not complete inasmuch as it studied the patient from his birth to the onset of the psychosis but did not study in detail the progression of the illness after its onset. Another difficulty in the longitudinal study of schizophrenia is its multiform clinical course, not comparable to that of any other known disease or condition. In fact, the same stage of regression that is reached by a patient in a period of a few days or weeks may be reached by another patient in a period of over half a century. A third difficulty consists of the fact, so well known, that different levels of regression do not appear in any case in pure culture; each case presents a mixture of several stages. It is only by artificial abstraction that we may reconstruct the individual stages.

Kraepelin spoke of progressive *deterioration*. Although he considered this characteristic of schizophrenia the fundamental one, he could not go beyond a descriptive approach because he did not use the Freudian concept of *regression*. Therefore he emphasized the type of symptomatology rather than the stage of the illness. It was more important for him to distinguish the three types—catatonic, hebephrenic, and paranoid—than to attempt to individualize any

stage. Later he added the simple type, after Bleuler. As was seen in Parts Two and Three of this book, these divisions in the four types were accepted in the present study, not purely from a descriptive point of view, but also because they indicate the prevalence of specific dynamic and formal mechanisms. However, I feel that it is also important to divide the illness into four successive stages: the initial, the advanced, the preterminal, and the terminal. The separate study of these stages further clarifies the intricacies of the disorder. [1]

In this part of the book we shall accompany the patient from the initial stage of the overt psychosis to the terminal stage. As he progresses from one stage to the following, he will be seen less and less in an interpersonal context and more and more in isolation, wrapped in his own symptoms, generally within the walls of the psychiatric institution. Those interpersonal relations that were of so much significance when we studied the prepsychotic stages lose importance when the patient succeeds in finding the path of progressive regression. The interpersonal relations of the past continue to act through the distortions they still engender, but the impact of new relations is diminishing progressively. That is not what we want, of course. If the few remaining interpersonal relations were

studied and corrected, as done by Stanton and Schwartz (1949a, b), or if the patients were exposed to a kind of "milieu therapy," as suggested by Rioch and Stanton (1953), it would become less likely that patients would follow the pattern described in this part of the book. The author hopes that soon the conditions described in Chapters 23, 24, and 25 will be things of the past, because the patients will not be allowed to go beyond the initial stage of the disorder. At the present time we must admit that these conditions occur and that we must face and study them in order to combat them more efficiently.

In this chapter we shall discuss only the initial stage of the disorder, which, as we have seen in Chapter 8, can start in numerous possible ways. In many cases, the beginning is slow and insidious, and it passes unnoticed. This is almost always the case in the simple type. On the other hand, in the other three types, the beginning may be either slow, acute, or very acute. We shall examine here only acute cases, which lend themselves better to didactical purposes.

## II The Onset of the Psychosis: Sequence of Early Substages

Many patients go through the substage of prepsychotic panic that we have described in Chapter 7. In a large number of patients this prepsychotic panic slips almost imperceptibly into a real psychotic stage. The patient may have some ideas that absorb him entirely, some fantasies and fears that may become delusions, some reluctance to act that may become withdrawal or even catatonic stupor. The following case shows some of these features.

At the time of the psychotic episode Fred was a 31-year-old, single, professional man engaged in research work in a university. The patient's father was a successful businessman. Fred had always felt distant from him, had always considered him as a man of action, not of thought, as a man rigid in his ideas, conventional, and authoritarian in imposing his will on the rest of the family.

Fred's mother was described by the patient as a submissive person who always did what the husband wanted. Although she had never been cruel or antagonistic toward her only child, no real closeness had ever developed between them. Her overprotectiveness, and also her ostensive agreement with the father, who was looking askance at Fred's peculiarities and unconventionalities, kept the

patient distant from her, too.

Fred's peculiarities were his habit of remaining alone for prolonged periods of time, his reluctance to cultivate friends and acquaintances or to celebrate holidays, birthdays, and other family gatherings, and his almost exclusive preoccupation with study and research. These peculiarities made it difficult for Fred and his parents to live together. Since his teens they almost always lived apart, Fred in university towns, the parents in New York City. Fred's contacts with girls were very few. His extreme shyness prevented him from seeking romantic companionship. He had, however, a relatively close relation with a rather aggressive woman, Rose, who initiated the friendship. Normal sexual relations occurred, but after a year and a half Fred and Rose broke off because he refused to marry her. Since then there had been no other relations with women. He felt inadequate and unattractive and feared establishing contacts with women.

In one field, however—his professional work—Fred always did much better than the average person. He was working in a theoretical field, and the papers he wrote were well received.

Sometime in spring, while he was involved in a certain piece of research, he became aware of new avenues of investigation to be explored in relation to his work. This complication would require a great deal of time, he thought. On the other hand, he knew that the professor, the chief of his department, wanted the work finished before summer vacation. Fred's anxiety about finishing his research increased. He worked on it without rest. He would skip meals, would not shave for days, would not leave his room except for some meals in a luncheonette or to visit the professor every two weeks and report on his work. He would work through the whole night, feeling that he could concentrate better during these silent hours. He would go to bed at dawn and would get up at two o'clock in the afternoon to resume his work. On the other hand, he became worried about other things that he had neglected for the sake of saving time. He had not filled out his state income tax return; his car, parked in the street, needed repairs and new license plates, and he had done nothing about it. His fountain pen was broken, and, because he could not go to buy a new pen, he was writing with pencils only.

Physically he did not feel well; he was run down. The work seemed to offer great promises, but somehow the solution of it eluded

him. He caught a cold and developed a fever. While he was lying in bed, he noticed that some fantasies would occur. These fantasies concerned his former girl friend Rose. At the beginning he felt he could stop these fantasies. He wanted to stop them because they were not pleasant. But, as he put it, a morbid curiosity got the best of him, and he continued for hours and hours to indulge in them. They concerned Rose and him, visiting an amusement park, going into the trailers of gypsies, and seeing a puppet show held in one of these trailers. While the puppet show was going on, he realized that the puppets gave him the optical illusion of distance, an enormous distance. All of a sudden he woke up from the fantasy. He told himself, "This is not a daydream; this is schizophrenia. I'd better stop it." But then the idea occurred to him that he could indulge in the fantasies because he had just proved to himself that he could stop them whenever he wanted. He is back then in the daydream. He is still at the puppet show in the trailer. He is sitting on a chair. He wants to get up, but he cannot. All of a sudden he sees that Rose pretends to operate the show, to make the puppets dance. He loses his temper; he is angry. He wants to go out. He yells, but he cannot move. Finally he succeeds in getting up, but feels that he is ill, extremely ill. He tells the owner of the trailer that he understands

those optical illusions. The puppet show is not an innocent performance, and he is going to expose him.

The fantasy seemed to stop at this point. Fred told me later that it was more than a fantasy. Although he knew that he was imagining things, these fantasies were perceived by him as vividly as if they were real. He did not remember what happened the following day. Later, however, he felt very sick, almost unable to move. He felt he was in the same way, or almost, as he had imagined himself to be in the fantasy, when he wanted to move and could not. As he put it, the impulse to move was not delivered to the hand or to the part of the body he wanted to move. The wish to move, now, was like the experience of a person who dreams and wants to wake up from the dream but cannot. At the same time he was still worried about the things he had to do: the paper, the income tax, the car, the license, the fountain pen. In the midst of his immobility he was overwhelmed by what seemed an avalanche of things he had to do. He felt confused; he could no longer understand things well. However, certain things started to appear strange. The place where he lived began to look peculiar to him. In reality that place had always been peculiar; it was an isolated house on a big lot in a slum that was undergoing demolition. The newspapers

had reported from time to time that some crimes had been committed in that area. The house where the patient lived was one of the last scheduled to be demolished, was run as a boardinghouse, and was inhabited by peculiar people. On one floor there was a couple who were deaf-mutes and another couple who were maimed. On another floor there were some entertainers who practiced their songs the whole day and left the door open. Confusion and noises were going on all the time. While confined at home, Fred succeeded during the day in moving around the apartment. One day he looked out and saw policemen passing by. The fleeting idea occurred to him that maybe they were looking for somebody who had committed a crime and that they would accuse him. For a few days, he also had a terrific pain in his testicles. He had the impression that a putrid odor was emanating from his nose. He was extremely anxious about everything. He felt that the house, too, was smelling peculiar and that maybe there was a leak in the gas pipe. He had a terrific headache, felt that he was possibly drugged or that he had undergone a hemorrhage in the brain. He did not have any definite idea of what was going on. He knew, however, that he was sick, terribly sick, and terribly alone. Finally he decided that he had to see the professor. With a superhuman effort he left the

room and went out of the house. On the way to the institute he felt almost unable to move. He had to give himself orders, as one usually gives to another person: "Go. Turn. Go ahead. Go in this direction." Only by doing that was he able to reach the institute. When he arrived there, he walked into the office of the professor and said, in a hesitant voice, "I am sick, maybe drugged." He was dirty and unshaven. From his appearance, expression, and voice, the professor understood immediately what was going on. He replied in a friendly, reassuring voice that he would accompany him to see the doctor on the campus. The doctor recommended consulting a psychiatrist. The professor accompanied Fred to the psychiatrist, who made the diagnosis of an acute psychotic episode, with hallucinations and delusions in formation, but no violence or agitation. The professor called up the family in New York, and it was decided that the patient would fly immediately to his parents, who would have him treated by a psychiatrist as soon as possible. The professor accompanied Fred to the airport, and he flew to New York.

When he arrived in New York, everything seemed to him in vivid color, like in technicolor movies. He felt better already, and the terrific experiences that he had undergone the previous days seemed to be

disappearing. When I saw him the following day, he was still somewhat confused and unable to concentrate, but at the same time he was recovering. He was able to explain the abnormal experiences he had had, and he seemed rapidly to reacquire a grasp on reality. In the following weeks we were able to analyze what had happened to him.

His deep insecurity, which originated early in life, was only partially compensated by the security that he was gaining in his academic work. The need for this security was such that everything else had to be sacrificed for the sake of this academic achievement. At the same time academic life permitted him to hide and maintain his schizoid personality. Any act of living that required closeness with others was for him more difficult than was his difficult research work. A rapid deterioration in his habits of living could be retraced when, during the treatment, we analyzed the years prior to his psychotic episode. Later the insecurity invaded the area of his work, which had previously remained immune to anxiety. He had new ideas about his research that he could not demonstrate as valid, and at the same time he thought the professor wanted the paper ready at an early deadline.

The anxiety increased enormously and finally produced a state of panic in which all the conflicts related to the other aspects of his life came again to the foreground. Thus in the fantasy about the puppet show, it was Rose, the domineering girl friend and his only girl friend, who was running the show, moving the puppets. He was like a puppet himself, manipulated by Rose, or a paralyzed man who cannot move. The image of himself, unable to move from the chair, represented, at a concrete level, his feelings of passivity. The fantasy about the optical illusion of distance was a concrete representation of his inner knowledge that the emotional distance, the detachment, was an illusion: he must live closely to someone.

It is interesting to consider the precipitation of events. Everything is confused, strange, frightening; he develops some paranoid tendencies. He has vague ideas, suspicions, is scared, knows that he is sick. His perceptions are distorted or intensified. He tries to make sense of the various impressions, like the police, the crime, the smell, but cannot. In other words, he tries to reach what later in this chapter we shall call "psychotic insight," but fortunately he cannot. What happens instead? He has a real insight. He must see the professor. He succeeds in overcoming partial catatonic tendencies and

goes to the professor. This man, who had threatened him with the deadline, was sympathetic, understanding, showed real concern, went out of his way. Fred did not feel alone any more; the needed encounter had occurred.

As he told me later, it was from the very moment he saw the professor that he started to feel better, that the delusional trends became weaker. The professor also did something else that showed unusual courage. He allowed the patient to come alone to New York by plane. Few people would have dared to do so. The professor could have been seriously criticized for allowing a person so sick to fly alone. On the other hand, Fred told me later that such a move from the professor helped him tremendously. It meant that the professor still had confidence in him, somebody trusted him. He was not hopelessly lost. We may ask ourselves where the professor got this courage. The professor intuitively understood that Fred could be trusted to fly alone, a feeling that we shall take again into consideration when we study psychotherapy (Chapter 36).

When Fred reached New York, the beneficial encounter was continued with psychotherapy. He recovered completely from the

acute episode and continued in his scientific career.

The case of Fred is a very interesting one from a didactical point of view. Although we do not want to deal with the topic of psychotherapy in this chapter, I shall mention that this case indicates that in some cases schizophrenia can be immediately reversible at its onset if the proper interpersonal encounter occurs.

In many other cases, although the patient is recognized as requiring psychiatric treatment, no definite prepsychotic panic or state of emergency is noticed prior to the psychosis. The schizophrenic episode seems to be precipitated by an apparently insignificant episode.-

I mention here the case of a veteran whom I saw only three times after his return from World War II. He had great difficulty in readjusting to civilian life and was uncertain as to whether he should reenlist in the army or not. He was engaged to be married, but had no position. At the end of the second session he felt that he did not want any more treatment, and I was not able to persuade him to continue. He felt that his only difficulty was the lack of an occupation and that

once he found a job every difficulty in his life would be solved. One of the reasons given for discontinuing treatment was that he had to go out of town to visit wealthy and prominent relatives who probably would offer him a good position. There were no psychotic symptoms at this time. Three months later I received a telephone call from his wife. She said that the patient was very ill and that I must see him immediately. The patient and his wife came to my office. I saw the wife first, who gave me the following history. She and the patient had been married a month previously. His relatives had not kept their promises, but the patient had had several odd jobs, and "everything seemed to be all right." Two days previously the patient had secured a position as a bus driver. The very morning that she called me, her husband had had a minor accident; his bus had collided with a car. No one was hurt, but the car was damaged. The damage would probably amount to two or three hundred dollars. She said that since the time of the accident. which had occurred about seven hours previously, the patient had been excited, restless, and had talked nonsense. The night before, they had talked about their future plans and had been very happy. The wife was pregnant, and they had been talking about the expected baby. According to the wife, the husband had shown no abnormality

whatsoever. The trouble started all of a sudden after the accident. When I saw the patient, he was restless and excited. He recognized that something very important was disturbing him, but he was not able to say what it was. During the interview my phone rang twice. Each time he thought that some people were calling me concerning him. They must be after him. They must know where he is. Because he heard the voice of a woman at the end of the line, he assumed that it was the voice of his aunt. She was talking to me about him. He did not know what was happening. Everything was confused, strange, and moving. The following are some of his statements, taken verbatim: "The world is going very fast; it keeps spinning on an axe [sic], but keeps going. If the people of the world are going a little faster, they try to go with the world, and they shouldn't. It is my desperate opinion that the people are rushing slowly and slowly and when they reach a certain point they start to realize that they are going fast or slow, and they cannot be judges of the world as it is spinning. The world has changed, is going fast, keeps going, going. I couldn't keep up with it."

I recommended immediate hospitalization. The patient was hospitalized in a veterans hospital, received shock therapy, and I heard later that he had made a seemingly complete recovery. Because I had

seen this patient only three times, I was not in a position to make an adequate dynamic evaluation of the case. After returning from the army, he had made an attempt to adjust to civilian life. The old personal difficulties, which were not manifested as long as he was in the army, made this adjustment difficult. At the same time that his difficulties increased, the demands made on him complicated the situation. He felt that as soon as possible he should marry the girl to whom he had been engaged for a long time and who had waited for his return. His relatives disappointed him, and his dependency on them was frustrated. Finally he secured a good position as a bus driver, and two days later had an accident. He thought that probably he would lose his position, and this belief reinforced his deep feeling of worthlessness. Whether he unconsciously provoked the accident, we are not in a position to say; of course, such a possibility exists. After the accident he broke down. The accident was to him the proof of his inherent inadequacy, especially because he gave so much importance to having a job. Almost all his security was precariously founded on his having a position. Now nobody would have any confidence in him. The relatives were right in not trusting him with a job. He was hopeless; he was not able to keep pace with life.

This case shows how a simple event, which can symbolically fit the vulnerability of the patient, may induce or unchain a psychosis, when the necessary ground is ready for it, of course. Because we know so little about this patient, we cannot understand the fundamental issue, that is, why he was so vulnerable that even the accident, in itself not a serious one, was capable of eliciting a major mental disorder. This case is nevertheless valuable for didactical purposes because it shows that a few hours after the clear-cut onset of the acute attack, the schizophrenic symptoms were already very pronounced. The patient's thoughts were disorganized. He saw the world in a different way, going fast, so fast that he could not cope with its movements. The abstract feeling of inadequacy was concretized in his not being able, in a physical sense, to keep up with the movements of the world. The accident with the car probably provided the idea of the movement. Ideas of reference were already in full swing, and paranoid concepts were developing. He already saw things in a different, confusing way, and was making an attempt to reinterpret reality.

Less acute onsets occur when the patient feels unable to satisfy excessive compulsions and falls into a state of panic. In several cases, some ideas that seem plausible acquire predominance in the patient's mind, so that he is not able to pay attention to other things or to answer questions that are not directly related to the problem he is thinking about. He feels confused and experiences vague feelings of discomfort. The conscious problem that worries him seems to possess him entirely. He wants reassurance very badly, but he is not capable of being reassured. Pertinent answers to his questions are almost not heard. He repeats the same question many times, and he is depressed and seems to suffer a great deal.

At times he succeeds in overcoming this state of torment, especially if fortunate circumstances occur, as in the case of Fred. The patient may snap out of this state and go back to his usual condition. At times he may feel better for a few hours or days, but then the panic returns, even stronger than before. He has the feeling that something terrible is happening to him. Maybe he is becoming insane. A little later he feels that people think he may be insane. He has the feeling he is losing a battle, an unknown battle. He becomes more and more discouraged. His confusion and fright become greater and greater; they overcome and submerge him, like big waves. Things seem peculiar, funny, have acquired a different perceptual quality and an obscure meaning. At times he finds himself indulging in some

fantasies, which he himself recognizes as false, and yet they are so vivid that they seem real. He tries to find explanation for all this, but he cannot.

Even at this point the patient may snap out of the confusion and return to his previous condition. On the other hand, if the fear increases, he may rapidly become unable to do things, to decide, to act, and more or less acutely he will lapse into a catatonic stupor. If the confusion increases, he may fall into a hebephrenic excitement. In many cases the patient feels that people are acting out a play to confuse him. The world becomes a big stage.

At other times, after a period of confusion, the patient feels that everything is clear. All of a sudden he experiences a flash of understanding. The light has come back. Things that appeared confused and obscure have a meaning, a purpose. He feels exceptionally lucid. He understands everything now; the strange events were not accidental, but purposely arranged. Somebody, somewhere, is after him, against him. From now on, and for a long time, the patient will try to demonstrate logically what seems evident to him. He develops the phenomenon that I have called *psychotic* 

*insight.* The psychosis is now well established in a paranoid pattern.

Why should we call this phenomenon psychotic insight? Insight means a sudden discovery of relationships and meanings between different things and facts. Certain things that before appeared to the patient as disconnected and unrelated are now seen as parts of a whole. But the insight is psychotic because only the patient sees these connections. To use his own words, he "puts two and two together"; he is able "to assemble the various pieces of a jigsaw puzzle." But only he is able to detect the puzzle. He is able to see the world in a different way because he adopts new ways of thinking. He abandons secondary process cognition and adopts the primary process mechanisms that we have described in Part Three. He feels that he has never thought as clearly and effectively as now. Such an impression is occasionally conveyed to the layman.

It is important to stress that the patient often does not acquire the new regressive ways of interpreting reality without first putting up a fight. When this new way of thinking lurks in the background and threatens to come to the surface, the patient tries to resist it at first. He feels a struggle within himself that is experienced as an "attempt to resist a tendency to give in." The patient is, however, afraid that sooner or later he will succumb. Succumbing in a certain way seems a pleasant temptation because it would seem to relieve the state of confusion. Stein (1967) described similar experiences in the patient who becomes psychotic: his effort to resist the seduction of the psychosis and finally his possible *initial consent* to the sense of becoming psychotic. Stein writes, "Now, even though he has this sense of utter powerlessness or of being a passive observer of his own destruction, he still from time to time makes abortive attempts to resist dying, just as a drowning man who cannot swim nevertheless struggles frantically."

When the patient finally succumbs and has psychotic insight, the opposite process occurs: he searches actively for this corroborative perceptual evidence. If a noise is heard, if the neighbor uses a special word, if a strange man is walking up and down in the street, all this is corroborative evidence that what he thinks is true.

At other times this psychotic insight manifests itself in a different way. The patient does not attempt to demonstrate the validity of his ideas. "He knows"; that is enough. His knowledge comes from an inner,

unchallenged certitude that does not require demonstration. "He knows." The "psychotic certainty" is something that impresses the examiner very much. For instance, a patient, a young woman who had been for three days in a state of confusion, panic, and acute delusional ideation, was examined by a psychiatrist who addressed her in this way: "Mary, I want to know about the confusion and insecurity that you have been in lately." She replied, "I prefer to talk about the security and certainty of today. Everything is clear to me."

The following case clearly illustrates the initial substages of the illness. I saw this patient just once for a checkup about five years after he had recovered from an acute attack. At the time of my examination he seemed to have made a satisfactory adjustment, he was happy, and he did not remember anything about the acute episode that he had experienced while he was in military service. The adjustment, satisfactory in every area that was considered, made me feel optimistic from a prognostic point of view.

The history of this patient revealed that while he was in the service during World War II he had made unsuccessful attempts to be discharged on the basis of hardship for the family. Shortly afterward

he developed an acute episode characterized by hallucinations and delusions. He misidentified people and felt that through television "they" were keeping track of his movements. He had somatic complaints and was argumentative. He received a course of electric shock treatments, developed amnesia for the episode, and made an apparently complete recovery. A few days after the onset of the psychosis, he wrote a letter to his family that described the beginning of his attack very well. Here are some excerpts from his letter:

... I entered the hospital and was admitted in Ward 1 for feet trouble, or better to cure a "wart" as they call it on my right foot. Well, to my surprise on the tenth day that I spent there the doctor made such a grin to me, that it finally dawned on me that I was there not for feet but for mental observation. the feet must have been just an excuse of which I was ignorant until then. When I discovered that, my first thought was to get out of the place; finally on the 12th day I was allowed to leave and it was Saturday. As I got out, the first breath of air that I inhaled made me feel as though I came out of a prison. At any rate, while waiting for the bus two fellows that I knew . . . picked me up and brought me to my squadron . . . they left me in front of my barrack and left; looking up, I saw that everybody was dressed and were going to the ramp on parade. . . . I sat waiting for the parade to be over. When they finally came back my first thought was to go to the orderly room to ask about a furlough which

I had been waiting from week to week. The next thing I remember at 12 o'clock I had to report on the line for duty which I did. There, to my surprise I felt out of place, fellows spoke to me but it didn't make much sense to me. I remember I got a splitting headache, at that time all the aeroplanes were gone cross country, there were very few left on the line. I went back to my squadron all puzzled and yet I was unable to figure it out.

The following day I went back on the line. They put me to work, but to my amazement I realized that I had forgotten to do the simplest things on an engine. Everybody looked at me with some sort of sneer. Then I was asked to stand fire guard on a plane; a certain sergeant . . . asked for a loan of \$5 and another fellow asked for a loan of \$2 to whom I gave. At night I heard lots of planes warming up engines on the ramp, everything seemed to be very noisy, cars coming and going and motorcycles. Everything in my surroundings seemed very strange, it just didn't make any sense. I used to go to the general hall almost afraid of everything. In the barrack one evening I heard some real beautiful music which I enjoyed very much, yet to my eyes everybody didn't seem very friendly.

The following morning I was made room orderly, cleaned all the barrack downstairs and upstairs; for some reason I knew that everybody thought I was crazy, I sat on the stoop and tried very hard to hold myself from crying. I cleaned the barrack extra just to show them I wasn't crazy and that I was as normal as others.

One night or perhaps in the early morning I felt as though my brain came back to me, it felt like little particles of sand going back in its place. The airplanes were still going on the ramp and I began to think. I try to find out what it was all about. All of a sudden I thought that the two extremes, too much quiet in the hospital and too much noise on the line, were the cause of it all. I got dressed and I went right back to the hospital and tell them what my trouble was. There to my surprise they didn't pay much attention to my saying and I went back to the squadron. On the way to the hall I thought some more and having in mind the expression of the doctor in the hospital, that noise of the aeroplanes which I don't think had ever heard before, it stroke my mind that it was no longer an accident but had been done purposely. I remembered this sergeant . . . ask me on the line if I wanted a discharge; well, then I put 2 and 2 together and I no longer thought but knew that the reason for the entire affair was just for that. In reality I was always preoccupied about home, my wife and child although they were in my father's house, yet that thought of me being in the army while many other married men were out really discomforted me. I wished I was out myself. . . .

Then I found myself in Room #6; here too I heard lots of noise, my mind has been on and off; I got to the point where I believed in many things, autos coming and going, birds, especially one to signify my wife, another to signify my penis, etc., etc., etc. Here I have seen my father and mother and two sisters, seen my wife twice; once on Oct. 12 a date which I shall not forget; my mind wasn't my own and

I didn't even move to meet her. From Room #61 was moved in back of the ward, then I had a fight with a sergeant and am presently under guard."

This letter remains an accurate document of the sequence of the events at the beginning of the psychosis. Because the distortions are not pronounced, they permit an easy understanding of the early development of the psychosis. Being in the armed forces caused the patient a great deal of apprehension and reinforced his anxiety. He had made attempts to be discharged and had not succeeded. Of course, we do not have any preceding history of the patient, and therefore we do not know why he was psychologically vulnerable. Obviously he could not accept being away from his wife and child and could not adjust to army life. The anxiety became intolerable and overwhelmed his defenses. His letter describes very well the dreamlike atmosphere of the first few days of the psychotic attack. It reminds one of Kafka's novels.

During these first few days things started to appear funny, peculiar, confused, dreamlike to him. When he reported for duty, after being discharged from the ward, he felt out of place; what people said made no sense, and they seemed to look at him in a sneering manner.

Everything appeared changed, everybody was unfriendly; he was afraid and felt that people thought he was insane.

After this first impression of confusion, bizarreness, and apprehension, the patient progressed to another stage. He felt that his brain was "coming back" to him. Things that were happening were no longer accidental but had been done *purposely*. He put "two and two" together, and everything became clear to him. The feeling of being insane was discarded; he acquired, as in a flash, psychotic insight. He was able to fit things together.

Thus we can recognize a sequence of phases: first, a period of intense anxiety and panic; second, a period of confusion, when everything seems strange and crazy; and third, a period of psychotic insight. When this psychotic insight occurs, the external world is understood according to a new system of thinking, which, of course, follows the motivational trends of the patient.

In the catatonic type of schizophrenia, the phase of psychotic insight is replaced by the catatonic state.

After this beginning of the psychosis, the usual symptoms of

schizophrenia flourish: hallucinations, delusions, ideas of reference, catatonic posture, and so forth. The patient has now lost the battle for the supremacy of his logical thinking. If he follows the catatonic pattern it is because he is overwhelmed by fear of actions. If he follows the hebephrenic path, he is swayed by the unconscious forces that will make him resort to paleologic thinking. If he selects the paranoid way, it is because he mobilizes the remaining conscious and logical forces in the service of his unconscious. That is, he will use the logical forces to corroborate and to sustain feelings and ideas that are emotionally determined and paleologically conceived. In the well-systematized paranoid, both the logical and paleological systems (or, if we prefer the original orthodox Freudian terminology, both the ego and the id) are at the service of the psychosis.

This *logical reinforcement* of delusional and paleological material at times reaches fantastic heights. Even in the beginning of the illness, the patient tries to give a logical appearance to phenomena that he experiences and that he himself recognizes as illogical. If he hears voices and does not know how the voices may reach him, he tries to explain the phenomenon by believing that hidden radios or loudspeakers transmit the messages. Hidden dictaphones or "wired"

rooms record everything he says, does, or even thinks. In past centuries psychotics explained their hallucinatory phenomena in terms of magic, sorcery, spiritism, and so forth, or, in other words, in terms that could have been acceptable in those days. In the hebephrenic type this need for apparent logicality is absent or greatly diminished. The patient accepts the delusional material without being concerned with the demonstration of its validity.

The symptoms of the first, or initial, stage of schizophrenia have already been described and discussed in this book. At this point we have to stress that although the psychosis is now in full swing and the primary process has taken over some of the functions that were under the domain of the secondary process, the psychotic state is not yet crystallized. A fight against the secondary process is in most cases visible. Anxiety is either present or can be easily mobilized. A spontaneous return to a prepsychotic level is not likely; and yet even a state of psychotic equilibrium is not reached, in spite of the symptoms. The symptoms may change, not only toward more or less regression, but also from one of the four major types to another. Thus, occasionally we see sequences of this kind occurring. A patient who in the beginning of the psychosis has a paranoid symptomatology may all

of a sudden change into a catatonic state. Subsequently he may become decatatonized and will exhibit paranoid symptoms again. These changes indicate that the patient searches every possible pattern in order to escape anxiety, and, unless fortunate circumstances take place, these changes are not necessarily hopeful signs.

In many patients, but especially in paranoids, the symptoms are such as to elicit unfavorable reactions in others, which, in turn, will increase the anxiety of the patient. A vicious circle is thus established.

The classification of schizophrenia into acute and chronic cases, which many psychiatrists adopt, has nothing to do with belonging to the initial stage or not. Obviously, when the patient has reached the second, third, or fourth stage, he may be called chronic in spite of occasional remissions and even recoveries. However, he may remain chronically ill at the first stage, too, although this happens less frequently. It goes without saying that every effort should be made to prevent the patient from proceeding from the initial to subsequent stages.

#### Notes

[1] The reader is reminded not to confuse *period*, as defined in Chapter 5, with *stage*. All the stages of schizophrenia belong, from a psychodynamic point of view, to the fourth, or psychotic, period.

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