# Third Period: Adolescence and Early Adulthood

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**Adolescence and Early Adulthood** 

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# Third Period: Adolescence and Early Adulthood

### **Further Aspects of the Prepsychotic Personality**

Because the early experiences have made the future patient awkward socially, clumsy in his activities, and somewhat inadequate in coping with life in general, his defects become more evident in adolescence and later, when he has to deal with a greater range of situations. We shall first examine adolescents and young adults who had developed a schizoid type of personality in childhood. Most of them will retain this type of personality, whose traits will be even more marked and obvious. Many of these youngsters appear markedly detached, as if something unnatural and strange divided them from the world.

In spite of this apathy and aloofness, little signs can be detected in them that indicate how their original sensitivity is ready to erupt to awareness. One of these characteristics is their lack of a sense of humor. They cannot stand a joke or anything humorous said about themselves. Sensitized as they are to environmental hostility, they see in the joke a pungent remark made against them. In this interpretation they are right, because many jokes and humorous remarks have an element of hostility (Freud, 1938; Arieti, 1950b). However, this element of hostility is so mild that it is not only tolerated, but often perceived as a pleasant teasing by the normal person. For the schizoid, a joke is a serious rebuff. For the same reasons, schizoids are poor losers at play. Defeat is another proof of their inadequacy and increases their already strong reluctance to do things with others or to share experiences.

Most of these schizoid persons develop other defenses or protections, which consist of unusually drastic actions or habits at a reality level, rather than *obvious* symptoms. The schizoid may enter a monastery, where he will be away from the dangers of life; he may join the Army, where he will be forced to respect authority; he may select some kind of work where he has to display no initiative whatsoever. In a considerable number of cases he may devote himself more and more to religion. In the belief and practice of religion he will try to get the comfort that he could not find elsewhere. Religion and God are the good parents, whom he substitutes for the bad parents. They are the

parents who accept even the inadequate and worthless children. The patient is unwilling to submit to the authority of his parents, but may respect the authority of God. He is not able to relate to people, but is able to develop some kind of relatedness to God. People do not give love, but God does. In some cases this escape into the church is a protection that may delay the psychosis. On the other hand, if in the association with organized religion the patient does not come into contact with some human beings and receive warmth and comfort from them, he may receive no help at all. Abstract concepts often do not provide what he needs. Some religious conceptions may slip into real delusions. On the other hand, because they seem so distant from daily reality, they may make unrealistic developments unnecessary. From a practical point of view, the religious fervor may push the patient in two directions. The patient may retain the religion of his parents, but may become much more involved in it than they were, or the patient may change his religion. By converting to a new religion, he fulfills several goals: (1) he rebels against his parents; (2) he tries to find in the new religion a solution to his problems, which he thinks cannot be solved if things remain unchanged; and (3) he tries desperately to make some satisfactory interpersonal relationships,

though they have to be in a very unusual form (convent, missionary work, mystical group, and so forth). Generally, the change in religion occurs from the more rational and abstract religion to the more mystical.

In some cases the schizoid person may alter his general behavior in order to become a member of a marginal or fringe group: a beatnik, a bohemian, a hippie, a marginally social person. In other words, his detachment from the type of life in which he grew up urges him to become attached and committed to a different life that does not require conforming. Moreover, he feels finally accepted by a group. The group requests from him less of a sense of responsibility and duty than society at large.

We must keep in mind, however, that most marginally social people never develop a schizophrenic psychosis. They remain marginally social for the rest of their lives or eventually return to a more accepted style of living.

A common defense among schizoid persons is that of decreasing their needs to an almost unbelievable extent. Many of them live alone in furnished rooms, away from social contacts of any kind, except those that are absolutely necessary. As we have already mentioned, fantasies, sexual or otherwise, replace their need for action. The fantasies often involve objectives that cannot be attained; therefore, any possibility of action is removed. When they are confronted with a situation requiring some action, they convince themselves that it is not necessary or worthwhile to act. They are able to work, but they do not let any emotion enter into their activities. Often they select a type of work that is impersonal and may be performed without any emotional involvement, for example, mathematics.

On the other hand, the schizoid, at some time during his life, may even become concerned over his lack of feelings. In spite of his detachment he knows that his life is dull and gray. He would like to become emotionally involved, but he cannot. At times he feels that he must pretend to have feelings and is afraid that people may "see through" him and recognize that he has no emotions. Actually, once he is successfully treated, he will discover not that he has pretended to have feelings, but the opposite, that he has pretended to have no feelings. Psychotherapy is difficult, first because of this lack of conscious feeling, and second because when the patient becomes

aware of his feelings, he is afraid to bring them up. He fears that they may be used against him to demonstrate how bad he is. He is still afraid that feelings would bring about rebuff, anxiety, and attacks on his self-esteem.

Adolescents with a stormy personality continue to be unable to build a relatively stable self-image. As we have seen in Chapter 5, they are the persons who, in childhood, could not build up the self-image of the bad child, but only the image of the *presumably* bad child. They also cannot establish an adequate sense of self-identity. We do not refer only to sex or gender identity. We mean also that the patient is not able to answer certain fundamental questions that he asks himself. Who is he and what do his family, acquaintances, and society at large expect from him? And if he ever finds out what others expect from him, would he be able to live up to these expectations? Even more crucial is the question of what he expects of himself. These questions are not asked in a general, abstract, theoretical, or philosophical sense. Philosophical questions of this kind are normal occurrences in bright adolescents and young adults. The preschizophrenic, and especially the stormy person, is concerned with these problems in a more concrete way and in reference only to his own specific interpersonal

and social situations. When we say that he asks himself these questions, we do not necessarily mean that he literally asks them of himself, although that may also happen. Often these questions and the inability to answer them remain at a nonverbal level, as a feeling of drifting aimlessly, a feeling of not being able to find oneself.

In both the schizoid and the stormy personalities self-esteem and self-identity are impaired, but self-identity is more impaired in the stormy personality. The schizoid person is to a certain degree more certain of his own identity, because he has accepted, at least to some extent, the self-image of the bad child. He resorts to detachment to defend himself; he becomes an inconspicuous follower, a wallflower, an isolated person. But the stormy person cannot compromise in that way. He is forever busy searching for his role, although he does not meet with success. He still tries to "reach" people, although he is hurt every time he tries. He still harbors ambitions, although he becomes increasingly discouraged.

The difficulties increase as the patient's inability to find his place extends beyond the family circle and involves a larger number of peers, acquaintances, and the community in which he lives. What role

does he play with them? What do they think of him? When later he enters the working world, the same uncertainty creeps in as inability to find himself as a member of a certain profession or trade. These feelings are further increased by the competition that he senses all around him. Although feelings of this kind are experienced by neurotics, too, they are much more pronounced in those prepsychotic individuals who have a stormy personality.

As already mentioned in Chapter 6, patients with stormy personalities often are compliant to a degree of extreme submissiveness; at other times they are aggressive and hostile; more seldom, they withdraw into an ivory tower of complete detachment. When they are not detached, they are very anxious; anxiety governs their lives. They are like schizoid persons who have been deprived of the protection of the schizoid defenses. They are, therefore, very vulnerable; every little event has the power of unchaining a crisis. The life of these persons in general is a series of crises.

In some instances these patients do not show sudden changes in character, but appear almost constantly either submissive or aggressive. Their submissiveness and pseudocompliance, to which we have already referred, may turn into obsequiousness or may become a caricature. Their aggressiveness consists mostly of loud manners void of results. Rather than to bring some relief, these attitudes provoke more anxiety and precipitate additional crises.

These patients often live in an atmosphere of catastrophe and doom. Still, they show an extreme resiliency, as mentioned before, and seem able to recover strength, spirits, and good humor easily. Generally, however, they do a poor job in covering up the underlying unrest with this gay, shallow, and effervescent attitude. When they are in a relatively good mood, they harbor grandiose fantasies and even paranoid tendencies. They are going to be great and successful, if they are just given a chance. They are going to get married to wonderful persons, and so forth. They like extremes only. For them, everything is black or white. Acceptance means devotion and love; nonacceptance means utter rejection and hate. There are no nuances in their lives. If the therapist accepts them, he must give all of himself to them. If they feel that the therapist rejects them, they go into a state of despair or detachment.

The changes in mood and attitudes do not relieve these patients.

They often resort to excessive use of drugs and alcohol. The crises they go through often weaken them progressively. These crises are frequently precipitated by little happenings, magnified by the patients, who unconsciously see in them symbolic reproductions of the original situations that produced anxiety. At other times, the crises are really precipitated by critical situations that arise as the anxiety of the patients forces them to inappropriate actions (marriage, love affairs, absurd jobs, and so forth). Things do not just happen to them, as they seem to happen to schizoid persons. The patients seem to search actively for a meaningful way of living. They actually live a stormy life, in a certain way comparable to the life that appears in the dreams of schizoid persons. [1]

Many schizoid or stormy persons never develop a psychosis. They retain a prepsychotic personality during their entire life, unless, of course, timely therapy or unforeseen circumstances direct them toward a different type of adjustment.

Some of these people increase the abnormality of their behavior so that many psychiatrists consider them preschizophrenics, latent schizophrenics, borderline schizophrenics, or even "psychotic personalities without psychoses." Most of them succeed in living a socially permissible, though inadequate, life. However, in many cases the schizoid or stormy character structures eventually no longer constitute adequate protection. The difficulties become more apparent the more the patient proceeds toward adulthood, for several reasons. The school situation, the increasing sexual desires, and the search for a position in a competitive world put his character armor to serious strain. The defenses that the patient was able to mobilize earlier in life used to be fairly efficient when he had to contend exclusively or predominantly with his family. Now he feels he has to deal with the world at large. In spite of his emotional detachment the schizoid person resents the fact that both the family and society demand that he relinquish his detachment and withdrawal—a request that he cannot fulfill. His schizoid defenses not only do not protect him, but actually handicap him when social pressures compel him to do things in spite of his withdrawal. He feels "pushed around." He does things haphazardly and halfheartedly and cannot exploit his full potentialities. The reduction of spontaneous activity confers on him a certain awkwardness and inappropriateness. His lack of experience in dealing with people increases his fears. When he succeeds in evading

his schizoid attitudes and in doing things, the old sensitivity tends to come back, and tremendous anxiety is experienced. The early uncanny experiences, which the patient has forgotten, continue to alter, or to give a particular coloring to, his present experiences. The persons he has to deal with are, symbolically speaking, other parents, and he has never learned to deal adequately with parents. The world appears to him to be populated by millions of authorities, ready to criticize him. Symbolically, every interpersonal situation is a reproduction of the old parent-child relationship; a compulsive attitude quite often compels the patient to make this reproduction more similar to the original situation than is actually required. The competitive spirit of our society, where everybody is supposed to assert himself or to show how good he is, makes his predicament worse. Handicapped as he is, it is no wonder that he fails. Any additional failure increases his feeling of inadequacy and predisposes him to subsequent failures. The series of failures and disappointments that Adolph Meyer was the first to describe takes place. The patient undergoes a progressive maladaptation and needs to withdraw into a stronger armor, with more defensive mechanisms.

This progressive maladaptation has many different aspects and

courses. At times, although it is very pronounced, it is not noticed by the superficial observer. On the contrary, the lack of emotional involvement and the slow tempo confer a certain poise on the individual that may even be appealing to some who do not recognize the underlying unrest. In other cases an insidious maladaptation leading to schizophrenia may become apparent even to the superficial observer, but only in some areas. For instance, the scholastic record may reveal a steady decline. The patient was a good student in grammar school, less than average in high school, and could not function at all in college.

The stormy personality continues to try to make contacts with the world, but without success. The pleasant reality he continues to crave continues to elude him. People see him more and more as a bizarre person who will never accomplish anything in life; he is indeed labeled a failure. This appraisal becomes obvious to him, or at least is suspected.

We may conclude that for both schizoid and stormy patients the intrafamily difficulties of the earlier periods continue to exist at later ages, although in a different context and with social implications. The

sense of distance, the lack of communication, the incomprehension, the unrelatedness between the patient and the others increase, although in stormy patients this situation is often not immediately recognized. The family drama or the social drama involving the patient and his milieu becomes more intense. Let us remember, however, that as long as this drama remains an interpersonal or social one and is not internalized in abnormal ways, schizophrenia is not present. In order to lead to schizophrenia the drama must injure the self very much and must become a drama of the self.

# II The Injury to the Self

Before determining how the self is injured, we must discuss an area of cognitive life, namely, conceptual life. We shall restrict our discussion to what is of particular relevance to the understanding of schizophrenia.

In my view, the conceptual part of the psyche is not a conflict-free area, nor merely a vehicle to mediate necessarily more primitive conflicts, but to a large extent it is the originator or transformer of the conflicts themselves. Human conflicts, both intrapersonal and

interpersonal, go far beyond instinctual deprivation and cannot be experienced without intricate conceptualization. What may prove most pathogenetic are not instinctual impulses or instinctual deprivations, but *ideas:* the cognitive part of man, which has been badly neglected in psychiatry. Freudian psychoanalysis, too, has either ignored the power of the idea or, when it could not ignore it, has attempted to transform it into a quantity of sexual libido.

As Vygotsky (1962) has illustrated, conceptual thinking starts early in life, but it is in adolescence that it acquires prominence. Conceptual life is a necessary and very important part of mature life. Some people, however, make an exaggerated use of concepts. They rubricize, tend to put things into categories, and forget individual characteristics. For these people the Platonic universals become the real things. Some adolescents who later become schizophrenics tend to select the formation of concepts and categories that have a gloomy emotional load, and these classes and categories are given an absolute, exceptionless finality.

Previous endoceptual experiences are now verbalized in negative contexts. Individual memories that had escaped repression continue to

bother the patient no longer as individual facts, but as concepts. Their emotional tonality is extended to whole categories and clusters of concepts that become complexes. Specific events, scenes, memories, like the creaking voice of the mother, the arrogant gesture of the father, the smoky and smelly kitchen, the dark living room, the disagreeable anecdotal happenings, are interconnected in a dreary web of feelings. Let us take again, as an example, the concept of mother, to which I referred in earlier chapters. We have seen how in the prepubertal period the earlier concept of mother, derived from the individual experiences, undergoes improvement because of the acquisition of the image of mother provided by the culture. The child had thus actually been able to overcome the formation of a primary process generalization and no longer included all mothers in one category. He became able to resist making this suggestible induction, and the subsequent deduction that each mother was a bad mother because each belonged to the same category. But now because of his unsuccessful dealings with the world, the future patient has come to the conclusion that all adults, and consequently mothers, are not loving creatures. They are also fakers, like his own mother.

From a psychiatric point of view, perhaps the more important

aspect of this expansion of conceptual life is the fact that the image of the self from now on will consist mostly of concepts. The image of the self varies through the ages. After several transformations in adolescence it consists of remnants of previous images, but predominantly of concepts.

The concept-feelings of personal significance, of self-identity, of one's role in life, of self-esteem now constitute a great part of the self. The self of the future schizophrenic will consist of concepts that have adverse emotional components.

Because of his adverse experiences the preschizophrenic continues to change in a negative way the image of the self. We have seen that in spite of his detachment the schizoid person has maintained and reinforced the image of himself as the bad child. But at a certain age, to be bad acquires the meaning of being incapable, inadequate, worthless, and even guilty for being so. The stormy person, in spite of his desperate attempts, will never find a reliable meaning for his existence. He will reach the point when he can no longer trust life as a possible source of pleasure or self-fulfillment.

This worsening of the self-image is to a large extent determined by the patient's new orientation toward time. We have seen that in the second period the future acquires importance and some optimism remains. In many cases the importance of the future and a sense of optimism are retained for a part of adolescence and young adulthood. In order to feed his present self-esteem and maintain a less inadequate self-image, the young individual has, so to say, to borrow from his expectations and hopes for the future. "One day it will happen," he secretly says to himself. But eventually he starts to doubt this belief. "Life is going to be bad," he says to himself. He also comes to feel that life is not necessarily bad for everybody, but that it is going to be bad for him. Eventually he may conclude that his life is going to be bad because he is bad or worthless. He feels that if he has always done wrong, it is because there is something wrong with him; if he has not been loved, it is not because love does not exist in this world, but because he is not lovable. The authorities that populate the world are malevolent toward him, and with good reason. He must hate himself more than anybody else hates him. His self-esteem undergoes the most injurious attacks. To some extent he protects the image of the external world, as he protected the images of his parents (see Chapter

5), but at the expense of having an unbearable self-image.

This devastating self-image in its turn compels the patient to change his conceptual understanding of other matters, and these changes in their turn will do further damage to the concept of the self. Let us examine again the example of the concept of mother. We have seen that often, after puberty, the patient generalizes and sees all mothers as bad and insincere. Later he develops another concept of mothers that has a more ominous effect than the previous one, even if it remains unverbalized. He comes to believe that no matter what woman would be his mother, even the best, she would be a bad mother for him because he himself is so undeserving and so bad that he elicits badness in others who try to be close to him.

# III Psychosexual Conflicts

Before proceeding with the course of events that lead to the disorder, we must examine more accurately the sexual life of the future patient from the time of puberty.

Sexual life is important also in the psychodynamics of

schizophrenia, but not in a relation of simple and direct causality. Psychological difficulties connected with the boy's first ejaculations and the onset of menstruation in the girl as a rule are not directly involved with the psychodynamics of schizophrenia. To be more specific, the possible revival in girls of an archaic fear of castration and the fear of eventual castration in boys who masturbate or who have wet dreams do not play an important role in the development of the disorder. Sexual deprivations, anomalies, or lack of sexual control may facilitate the occurrence of a psychosis only when they affect injuriously the self-image.

We have already mentioned that one of the most common sexual difficulties consists of the inability on the part of the future schizophrenic to establish a definite and stable sexual identity. Although the occurrence of this difficulty cannot be evaluated statistically with accuracy, I would roughly estimate that it is one of the most common, if not the most common.

In the second period of development, as described in Chapter 6, the young individual succeeded in hiding the sexual uncertainty transmitted from the first period and reached some kind of sexual identity; but, as we have already mentioned, this identity was not deeply grounded and was later easily shaken by the events of life. The unfavorable dealings with the world reinforce in the patient the feeling that he or she is not really a man or a woman. He sees himself in an ambiguous position. [2]

Next in frequency among the sexual difficulties of the preschizophrenic is homosexuality, both in its latent and overt forms. Until not too long ago in psychoanalytic theory latent homosexuality was considered the major etiological factor of paranoia, paranoid states, and paranoid types of schizophrenia. This conception was first expressed by Freud in his report on the Schreber case (Freud, 1911).

Some confusion still exists about the meaning of "latent homosexuality." This term does not mean that homosexuality is not practiced. It means that the patient is not aware of his own homosexual orientation. Even a person who does not have homosexual relations may be aware of his homosexual tendency. In this case he has a manifest form of homosexuality. The latent homosexual has become aware since early life of the extreme hostility with which society views this type of sexuality. Homosexuality thus

becomes unacceptable also to him. The patient consequently makes strong efforts to repress his own wishes or to divert them into other areas. To a large extent this repression is successful. Sooner or later, however, the patient can no longer repress these wishes. In Chapter 8 we shall see that irrepressible sexual desires may injure very much one's concept of oneself.

In my experience, as well as in that of many other psychiatrists, the importance of homosexuality in the etiology of all paranoid disorders has been exaggerated. There is nothing specific in latent homosexuality *per se* as a cause of psychosis. Homosexuality in several cases leads to psychological decompensation only because it engenders a great deal of anxiety in the patient who is no longer able to repress this "unacceptable" sexual orientation. In a hypothetical homosexual society, or in a society that would not discriminate against homosexuality, this psychosexual conflict would not exist or would not have the power to lead to a psychosis.

I must also stress that, according to my clinical findings, not only latent, but also overt, homosexuality has a role in the psychodynamics of several cases of schizophrenia. Here again social ostracism rather

than homosexuality *per se* is the pathogenetic factor. I could not obtain relevant data for comparing the incidence of overt homosexuality in schizophrenics and in the general population, and therefore I am not in a position to say whether a difference exists. In the cases of overt homosexuality the psychological difficulty emerges not from the effort to repress the sexual urge, but from the effort to suppress it. The patient eventually succumbs to the desire, although according to my findings somewhat later in life than nonschizophrenic homosexuals. The patient may become an impulsive or compulsive homosexual, and consequently he may be in constant conflict with society.

Most probably the early identity difficulties that predispose the patient to homosexuality are related to those that predispose him to schizophrenia. However, there are some justifications for believing that homosexuality as an organismic organization, even if psychological in origin, preceded the formation of a definite self or of self-image. In late childhood and adolescence, cognitive processes make the patient realize the social implications of homosexuality, and the self-image may be unfavorably affected.

A third common cause of psychosexual conflict in the

prepsychotic is the feeling of inadequacy as a sexual performer. This feeling is usually part of a general feeling of inadequacy. However, the general feeling of inadequacy is reinforced by the concept of the self as sexually inadequate, and a vicious circle originates.

In my experience these feelings of sexual inadequacy in the preschizophrenic do not originate from castration threats or from brooding over the size or shape of one's genitals. These preoccupations are generally a pretext, or a particular channeling of a previously existing feeling of inadequacy.

Sexual indifference or lack of concern about sexual life is also found in a certain number of preschizophrenics. This detachment from what pertains to sex is generally part of the schizoid type of relating. Originally it was a defense against an anxiety-provoking environment, but subsequently it becomes part of one's life pattern. Still, some schizoid persons retain strong interest in sexual matters and repeatedly masturbate. At times indifference for sexual matters occurs at the onset of the psychosis. According to Rado, "anhedonia" or pleasure deficiency, including deficiency in experiencing sexual pleasure, is an inherent characteristic of the preschizophrenic and

schizophrenic. According to my findings, these patients prove to be able to experience pleasure fully once they have overcome their psychological difficulties (see Chapter 37).

If the future psychotic feels inadequate as a sexual performer, he feels even more inadequate as a sexual partner and as a love object. Feeling undesired sexually and unloved are experiences injurious to the self, but feeling unlovable and undesirable is even a more devastating emotion. In other words, what is particularly damaging is not the idea that the patient does not obtain love or sexual gratification *now*. It is the idea that his constitution and personality make it impossible for him ever to elicit love or sexual desire.

These unbearable feelings at times compel these patients to impulsive behavior aimed at proving at least a minimum of sexual adequacy. Patients become promiscuous in order to reassure themselves that they can be accepted as sexual partners.

Another psychosexual conflict of the preschizophrenic, which used to be common in the past, is now rather rare. It consists of the fear, on the part of the patient, of succumbing to his or her own

heterosexual desires, at times with undesirable partners, with partners objected to by the families, or in ways not sanetioned by society. This conflict occurs in adolescents or young adults brought up in puritanical, Victorian, or very religious cultures. A greater acceptance of sexuality or even of masturbation as a sexual relief has caused an almost complete disappearance of this conflict, even in the preschizophrenic.

Summarizing, we can make the following statements about sexual conflicts in the preschizophrenic:

- These conflicts are not specific and may occur also in persons
  who never become psychotic. Only uncertainty about
  sexual identification seems to be considerably more
  common in the preschizophrenic.
- 2. In relation to the psychodynamics of schizophrenia, sexual life is not important in itself, but only insofar as it may affect injuriously the self-image. Either because the patient sees himself as a sexually inadequate person, or a homosexual, or an undesirable sexual partner, or lacking sexual self-control, or having no definite sexual identity, he may develop a devastating concept of himself. Moreover, in the case of lack of definite sexual identity, there is a continual draining of the resources

of the person who strives toward self-identity.

# IV The Prepsychotic Panic

The efforts made by the patient either to change his relation with the world or to adapt his self to the inner and external difficulties have not resulted in effective protection. To some extent the conclusion is reached, consciously or unconsciously, that the future will not redeem the present or the past. It is when the patient comes to believe that the future has no hope, that the promise of life will not be fulfilled, and that the future may be even more desolate than the present that the psychological decline characteristic of this third period reaches its culmination. He feels threatened from all sides, as if he were in a jungle. It is not a jungle where lions, tigers, snakes, and spiders are to be found, but a jungle of concepts, where the threat is not to survival, but to the self-image. The dangers are concept-feelings such as that of being unwanted, unloved, unlovable, inadequate, unacceptable, inferior, awkward, clumsy, not belonging, peculiar, different, rejected, humiliated, guilty, unable to find his own way among the different paths of life, disgraced, discriminated against, kept at a distance,

suspected, and so on. Is this a man-made jungle created by civilization in place of the jungle to which primitive tribes are exposed? The answer lies in the understanding of a circular process. To a large extent the collectivity of man, in its historical heritage and present conditions, has made this jungle; but to a large extent the patient, too, has created it. Sensitized as he is, because of his past experiences and crippling defenses, he distorts the envi ronment. At this point, his distortion is not vet a paranoid projection or a delusion in a technical sense. It is predominantly experienced as anguish, increased vulnerability, fear, anxiety, mental pain. Now the patient feels not only that the segmeni of the world that is important to him finds him unacceptable, but also that as long as he lives, he will be unacceptable to others. He is excluded from the busy, relentless ways of the world. He does not fit; he is alone. He experiences ultimate loneliness; and inasmuch as he becomes unacceptable to himself, he also becomes somewhat alienated from himself. It is at this point that the prepsychotic panic occurs.

A schizophrenic panic has been described by Sullivan (1953a). Sullivan considered it the outcome of injury to self-regard. He also described it as disorganization, terror, perception of danger, need to

escape. He explained it as "an acute failure of the dissociative power of the self," that is, of the mechanisms that keep unpleasant memories in repression. In my opinion, it is preferable to distinguish the prepsychotic panic from the psychosis. I consider the prepsychotic panic much more than "an acute failure of the dissociative power" and of injury to self-regard, although it includes these processes. It is at first experienced as a sort of strange emotional resonance between something that is very clear (as the devastating self-image brought about by the expansion of the secondary process and of the conceptual world) and something that is unclear and yet gloomy, horrifying. These obscure forces, generally silent but now reemerging with destructive clamor, are the repressed early experiences of the first period and their transformations in accordance with the laws of the primary process. In other words, either because of their strength or because of their inherent similarity to primary process experiences, the ineluctable conceptual conclusions reached through secondary process mechanisms, and their emotional accompaniment, reactivate primary process mechanisms and their original contents. These resurging mechanisms reinforce those of the secondary process, because they are in agreement with them, and the result has dire

proportions and consequences. It is this concordance, or unification of the primary and secondary processes, that (1) reawakens the primary process and (2) completes and magnifies in terrifying ways the horrendous vision of the self. In the totality of his human existence, and through the depth of all his feelings, the individual now sees himself as totally defeated, without any worth and possibility of redemption. In the past he had undergone similar experiences, but they were faint; now they are vivid. They are vivid even though they are not verbalized and occur in a nonrepresentational, almost abstract form. They include experiences that cannot be analyzed or broken down into pieces of information and yet are accompanied by increasingly lugubrious feelings. At times a drastic change is experienced dramatically; the patient may wake one morning and feel he cannot get up from bed and go to work or to school. Everything seems useless, meaningless, or frightening. He cannot accept life or himself anymore. He does not dare express these feelings in words. In many cases he would not be able to do so. Nevertheless, in some circumstances he tries to appeal for help. This occurs not too seldom in youngsters who are away in camps or colleges. These appeals are often misunderstood. Occasionally an almost "magic encounter" occurs with a person who is able at once to reach psychologically a patient; in other words, this other person is able to relate to him, to change his secondary process vision of the world, and to arrest the psychosis (see Chapter 22).

### **Notes**

- $\boxed{11}$  In an article published in 1962, Greene expands and clarifies my concept of the stormy personality .
- [2] After the onset of the psychosis, this lack of definite sexual identity becomes manifest in the overt schizophrenic symptomatology. The different gender identity that the patient may assume and his drawings of human figures with characteristics of both sexes are expressions of this psychosexual conflict.

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