

*INTERPRETATION OF SCHIZOPHRENIA*

**Recapitulation  
& Interpretation  
of Schizophrenic  
Regression**

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# **Recapitulation and Interpretation of Schizophrenic Regression**

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e-Book 2016 International Psychotherapy Institute

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## Recapitulation and Interpretation of Schizophrenic Regression

In the previous chapters of Part Four we have seen the long and multiform course of schizophrenia, from the initial to the terminal stage. We shall try now to recapitulate what we have reported in detail and to interpret the factors that in many cases make this regression unavoidable.

We have seen how an uncoped-with state of anxiety and vulnerability, whose roots are to be found in early childhood, makes the patient enter the first stage of the disorder. In the first stage archaic mechanisms that are dormant in every human being become again available to him. The patient resorts to them when any other method of decreasing the anxiety that injures the inner self and of maintaining his own individuality has failed. In the first stage the patient is still struggling between the world of reality and the world of his symptoms. He is not *completely* regressed to any particular level and is still experiencing anxiety.

In the second stage, this fight between reality and illness is over. There is no apparent emotional turmoil. One feels that the patient has more completely regressed to a lower level. Paleologic thinking and desocialization prevail. The patient seems to have accepted his illness; but the illness does not seem to have accepted the patient at this stage and seems to require further regression. How is this to be explained?

Throughout this book it has been maintained that when the dynamic factors compel the patient to develop schizophrenic symptoms, there is a regression. We have to remind the reader of what was discussed in Chapter 15. The regression is purely functional in the sense that discarded mechanisms become available again. However, the patient, even in a purely functional way, cannot *integrate* at lower levels. Biologically, psychologically, and socially he is not fit to integrate at a level that is not originally his own. What he will undergo is a *regression*, but not an *integration* at a lower level. Perhaps an example from biology will clarify this issue. Lower animals, who do not have a cerebral cortex, are integrated at a non-cortical level of development. For their kind of life, they do not require a cerebral cortex. But a higher animal without a cerebral cortex does not function like a healthy animal of noncortical species. He is in a pathological

condition, because his whole organism, each part of it, was integrated at a level that required the cerebral cortex.

No matter how much the schizophrenic regresses, he cannot become a healthy infant, he cannot become a presapiens man, he cannot become a chimpanzee. Children, ancient men, and apes are totally integrated at their respective levels; the schizophrenic is not. He will not even be able to exploit the reduced potentialities of the levels to which he regresses. For instance, we have seen that when in the terminal stage many sensory perceptions are impaired, the patient cannot exploit the ancient olfactory sense as much as he potentially should be able to, because his total organism, like the organism of every man, is not organized for the prominence of this sense. In other instances, it is true that he will repeat compulsively actions and habits of the levels to which he regresses, such as the hoarding habit, or placing-into-mouth habit, and so forth. These habits, however, have lost their original purposeful meaning and are not integrated with the rest of the life of the patient. No matter how much the patient regresses, he will always be disintegrated. This process of disintegration is enhanced by another phenomenon that, as we have seen, occurs repeatedly. This phenomenon consists of the fact that

when a higher level is out of function or does not function properly, several lower levels are disinhibited at the same time and interfere with one another. The schizophrenic patient is thus obliged to operate at several levels at the same time. This adds to the confusion, and increases the disequilibrium and the disintegration. But disintegration is not a state that nature accepts. Then how does the patient defend himself from it? With further regression. The same mechanism is repeated all over again. Regression engenders further regression.

The patient has reached the third stage when his voluntary life is much impoverished and certain primitive habits acquire prominence. The prominence of these primitive habits reveals a marked reorganization of the psyche in its relation to external and internal objects. External objects do not exist any longer in themselves, as objects of contemplation, and the concepts that constitute their corresponding inner objects are gradually being destroyed by the prevailing of primitive cognition.

The hoarding habit has, among others, the important purpose of counterbalancing transmutability and of retaining some inner objects in an evanescent world. When the patient regresses further, he shows

a tendency not only to collect these objects, but also to make them become part of himself by putting them in the natural cavities of his body (vagina, mouth, anus, auditory canals, and so on). When he regresses further and reaches the terminal stage, he does not grasp the objects any longer for the purpose of collecting them but in order to ingest them. He places them indiscriminately in his mouth, no matter whether they are edible or not.

Examining these phenomena in a longitudinal section, one is induced to believe that one habit is just a continuation or transformation of the other; first, the objects are collected, then an attempt is made to incorporate part of them, finally they are totally incorporated by ingestion. We have here a bizarre reproduction in reverse of phenomena that occurred in phylogenesis. Object relation becomes more and more primitive. Symbolic processes are bypassed, and the residual and habitual relations with the world assume the structure of primitive stimulus-response mechanisms. Low species grasp or pick up only what they eat or use right away. The newborn baby is concerned with activities that involve his mouth; only much later will he become interested, not in ingesting objects, but in collecting them.



At the terminal stage of the illness many patients also show those quasi-neurological alterations that we have described in the previous chapter. These alterations indicate a regression to a level where even many of our common perceptions do not exist. At this level the organism is able to experience some sensations only when they are deprived of perceptual elaborations.

From the preterminal to the terminal stages there is a progressive decrease of the processes involving apperceptions and perceptions. The actions of the patient are responses that are less and less meditated, and more and more primitive, almost like reflexes. Finally it seems as if some of the sensory stimuli are not even perceived or recognized, although they are experienced as sensations. Are these perceptual alterations a further step of teleologic regression, the final unique outcome of a progressive self-perpetuating regression? It would seem so. The patient seems compelled to escape from perceptions, and he functions like a person suffering from psychic agnosia.

What is the relation between the reported observations on regressed schizophrenics and the libido theory promulgated by Freud?

The oral tendencies seem to be manifestations of what Freud calls the oral stage, and the hoarding tendencies seem to be manifestations of what Freud calls the anal stage. I do not think it necessary to interpret schizophrenic regression in accordance with the libido theory. The phenomena observed in the schizophrenics are not due to an arrest of sexual energy but to a functional return to lower levels of integration. The crucial points are the availability and refunctioning of different hierarchical levels.

The oral tendencies of the newborn infant are biologically determined. As Thompson (1950) puts it, the newborn infant is chiefly a mouth. At birth the most mature part of the cortex is that which presided over the functions of the oral cavity. Erotic pleasure, if it exists at all, is incidental. The pleasure that the baby and the regressed schizophrenic attain with their oral tendencies derives from the relatively few functions that they are capable of at their level of integration.

The desire to collect without incorporating the objects requires a much more differentiated neurological apparatus. It requires, among other things, the ability to anticipate the future. The perceptual

alterations described in the previous chapter are also difficult to explain with the libido theory.

In summary it seems to me that all these manifestations, among which are those that are called anal and oral, are symptomatic not of an arrested sexuality but of lower levels of functional integration that have lower psychological and, at times, neurological organizations. At each of these levels, when they appeared originally in phylogenesis, a mature sexual development could be reached; but when regression occurs, sexuality cannot integrate well to lower levels, for the reasons mentioned in this chapter.

At this point we must conclude that if the first part of this book has helped the reader to consider schizophrenia as a syndrome, the second part as a psychodynamic process, and the third part as the adoption of a special psychological structure, this fourth part has illustrated another dimension, which can be observed only when the disorder is not cured or arrested: namely, regression, viewed as a movement toward less and less differentiated mechanisms and forms. Schizophrenia appears again as an entity and a process.

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## Acknowledgments

I wish to express my indebtedness to the publishers who have permitted the reproduction in this volume of long excerpts and/or illustrations from the following articles of mine:

“Special Logic of Schizophrenic and Other Types of Autistic Thought.” *Psychiatry*, Vol. 11, 1948, pp. 325-338.

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“Schizophrenic Art and Its Relationship to Modern Art,” *Journal of the American Academy of Psychoanalysis*, Vol. 1, pp. 333-365. © 1973 by John Wiley & Sons.

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