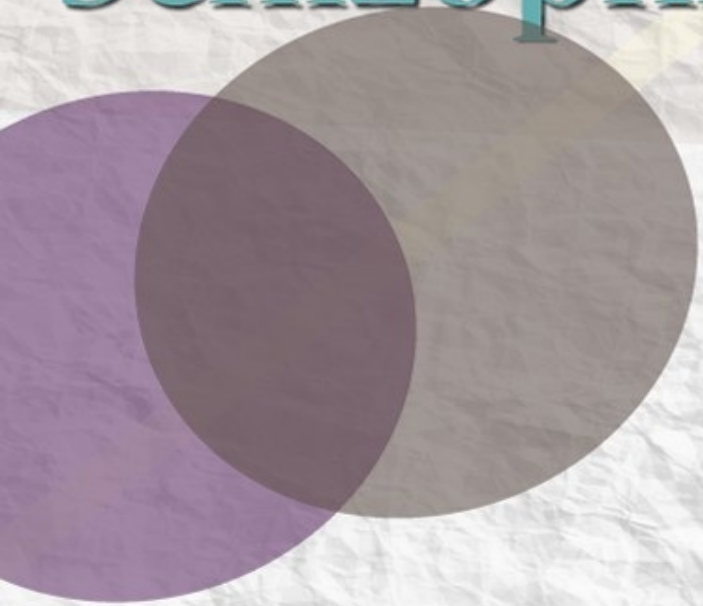
INTERPRETATION OF SCHIZOPHRENIA

The Concept of Schizophrenia



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The Concept of Schizophrenia

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The Concept of Schizophrenia

In this final chapter I shall pursue three aims. First, I shall discuss whether schizophrenia as a concept should be retained in spite of recent attacks. Second, I shall examine some theories which are not included or derived from the works of the six innovators discussed in Chapter 2. Obviously we cannot discuss all of them, as the number is enormous and always increasing. My discussion will be succinct and limited to three theories which have received much attention respectively in Russia, German-speaking countries, and the United States. Third, I shall give a last expression to some of my concepts, more amply formulated in the various parts of this book.

I
Attacks on the Concept of Schizophrenia

A considerable number of American authors are reluctant to accept schizophrenia as a clinical entity or as a distinct syndrome. Some of these authors have found support and inspiration in the writings of Bleuler, the very man who coined the word *schizophrenia.* In Chapter 2 we have seen that Bleuler himself delivered two blows at

the concept of schizophrenia as a distinct psychosis. The first blow was inflicted when he included in Kraepelin's category of dementia praecox many syndromes that at that time nobody considered related to schizophrenia. The second blow was inherent in the concept of latent schizophrenia. However, most American authors who are critical of the concept of schizophrenia found their earliest inspiration in the writings of Adolph Meyer.

Meyer did not deny the existence of schizophrenia as a clinical entity. However, the fact that he saw a continuity, or a longitudinal sequence, between the prepsychotic state and the psychotic was interpreted by many as an obliteration of diagnostic boundaries. There would be no schizophrenia but only progressive maladjustment.

One of the most vigorous attempts to abolish the concept of schizophrenia was made by Szasz (1957*d).* Szasz called the word *schizophrenia* a *panchreston,* a term coined by Hardin to denote dangerous words that are purported to explain everything, but that actually obscure matters. Szasz wrote:

> . . . categories such as "schizophrenia" may be doubly harmful: first, such categories are unsatisfactory as readily

> validatable concepts for purposes of classification, and secondly, they give rise to the misleading impression that there "exists" a more-or-less homogenous group of phenomena which are designated by the word in question. If this line of thought is correct—as I believe it is—it leads to the realization that the "problem of schizophrenia" which many consider to be the core problem of psychiatry today, may be truly akin to the "problem of the ether." To put it simply: There is no such problem.

Szasz added that "a better comprehension of the 'real facts' . . . will probably lead to the gradual disappearance of this word, whose function, like that of all panchrestons, is to fill a scientific void."

Other authors have stressed the similarity of the psychodynamics of many psychiatric syndromes and have tended either to include in the concept of schizophrenia the multiple conditions with similar psychodynamics or to abolish the concept of category completely. In my opinion it is a basic error to assume that it is in the psychodynamic mechanisms that we must find the individuality or specificity of schizophrenia. The psychodynamic factors, including parental attitudes, childhood situations, development of particular personality traits, and occurrence of special events, are very important. Although without them there would be no schizophrenia, they in themselves do

not constitute schizophrenia or the whole etiology of schizophrenia. We have the phenomenon schizophrenia only when the psychodynamic content is translated or channeled into a special psychotic form. For instance, an irrational feeling of self-depreciation and guilt, with special reference to the sexual area, may be evaluated in its great dynamic import and traced back to abnormal relations with the patient's mother. However, only when this conflict assumes special forms—for instance, that of a hallucinated voice that tells the patient that she is a prostitute—can we talk of the presence of schizophrenia. In the presence or absence of other factors, conflict of guilt could have been channeled in different ways, for instance, into phobic or obsessive-compulsive symptoms.

Several authors have repeatedly stressed that there is only a quantitative difference between the schizophrenic, the neurotic, and the normal. This point of view has been strengthened by the fact that in recent years clinicians have observed an increasing number of schizophrenics with such mild symptomatology as to make the traditional diagnosis quite difficult. The point is no longer made whether we are dealing with latent schizophrenia, as Bleuler did, but whether the distinctions between diagnostic categories should be

retained. Whether the increase in mild cases is only apparent and connected with the availability of a large number of psychiatric facilities or whether it is real and engendered by sociocultural factors is a question difficult to answer at the present time. Kubie (1971) writes, “At last a rebellion against the concept of schizophrenia is in full swing. Recently many psychiatrists are gradually coming to realize that this combination of a misconception and a misnomer has led us up blind alleys.” Kubie recognizes various degrees of psychotic disorganization, but he sees no need for a separate subcategory among psychotic disorders called schizophrenia.

Before Kubie, Karl Menninger strongly advocated the abolition of diagnostic categories. In his book *The Vital Balance* (1963) he suggested eliminating not only the concept of schizophrenia, but also all psychiatric categories. However, he recommended his own classification, which consists of grouping mental patients in five categories of “dyscontrol.” In a symposium on schizophrenia (1969) he repeated his attack, stressing also that an additional reason for rejecting the term *schizophrenia* is the fact that this word has acquired a pejorative connotation. According to Menninger an additional psychological trauma is inflicted on the patient who knows he has

been diagnosed as schizophrenic.

I believe that when psychiatrists examine typical cases, for example, a patient who states that he is Jesus Christ because he drank Carnation milk and therefore has been reincarnated, or who uses peculiar neologisms or metonymic distortions or typical word-salad, or who sees everywhere FBI agents spying on him, or hallucinates all the time, or is in catatonic postures, or complete withdrawal, they are confronted with a constellation or gestalt that cannot be confused. Certainly no pejorative connotation should be given to a dysfunction of the human being; but if human beings are inclined to do so, they will not refrain from attaching sooner or later a pejorative connotation to the name that replaces the old one.

As we have seen in Chapter 16, normal people occasionally become suspicious in a paranoid-like way; they misinterpret, they make slips of the tongue and unpredictable puns. But these phenomena of everyday life do not make a schizophrenic gestalt.

Even if we adhere to the continuous hypothesis and believe that psychiatric pictures may change by infinitesimal increments, that is, by

steps too small to be noticeable, we must be aware of the qualitative differences that may result depending on when and where the change occurs. The difference between 34° and 33° F does not have the same significance in relation to water as the difference between 33° and 32° F. There may be only a quantitative difference between a 39 percent and a 41 percent water solution of a substance, but if the dissolved substance precipitates when the concentration is 40 percent, the two solutions will no longer be only quantitatively different. They will also become qualitatively different, because one has a precipitation and the other has not. The situation is more complicated in the field of biology, and especially in the field of psychology, where the element of subjectivity enters. There may be only a quantitative difference in wavelengths that are responsible for the fact that we see various colors, but indeed we do see a variety of colors.

A person may have symptoms similar to those of the schizophrenic, but it is only when he accepts them as part of reality, integrates them into the context of his whole life, and consequently experiences the world and himself in a different way and alters his relationship with others that the total quality changes and the psychosis emerges.

Similar remarks can be made in relation to homosexuality and heterosexuality. We may find some homosexual conflicts in many heterosexual patients, but it is only when the individual integrates his own sexuality along a homosexual orientation that we consider him homosexual. There is no doubt that in by far the majority of cases it is possible to decide whether a given individual is homosexual or heterosexual.

In reference again to schizophrenia, we must attempt in Hegelian terms to lay bare the core and significance of the psychotic event, to free it from the adventitious contingencies that, although not irrelevant accessories, are only partially causally related and of merely secondary importance.

II
Three Additional Theoretical Frameworks

Pavlov and the Pavlovian School

After his visits to the psychiatric hospital of Vdlenaja and to the Third Psychiatric Hospital of Shvortsov-Stepanon in 1918, Pavlov developed great interest in schizophrenia, especially of the catatonic

type, and tried to attempt a physiological interpretation of its symptomatology.

In one of his important psychiatric papers (1919) he described two cases of catatonia. The first concerned a 22-year-old girl, and the second a 60-year-old man who had been hospitalized for twenty-two years. His catatonic illness had started around the age of 35 and had continued for many years. But when the patient approached the age of 60, there was a rapid disappearance of the catatonic symptomatology. This patient told Pavlov that during the years of catatonic stupor he was conscious of everything that was happening around him, but "that an extreme and unconquerable heaviness of his muscles" made it difficult for him to move, eat, talk, and even breathe. Pavlov compared catatonic patients to experimental animals that have been conditioned. The motor inhibition, although possibly chemical in origin, would be fundamentally functional in nature and would have to be interpreted as an irradiating inhibition spreading to the motor cortex. In a second article (1930) Pavlov interpreted schizophrenia as a chronic state of hypnosis caused by hereditary and acquired weakness of cortical cells. Social factors in critical periods of life may also contribute to exhaust the cortical cells. According to Rochlin (1969) with these statements

Pavlov implied that cortical inhibition is a defense, that is, it has a protective function. Pavlov compared the negativism of the catatonic to the negativism of the conditioned dog who withdraws from the food at the beginning of the experiment and then goes toward the food when it is withdrawn. According to him the conditioned stimulus (sight of food) reaches the point of the cortical motor area whose stimulation provokes in the dog a movement toward the food. But inasmuch as the cortical point is weakened, it responds abnormally, that is, not with excitation but with inhibition. When, instead, the food is withdrawn, the cerebral area that had been inhibited and that was connected with the movement toward the food is now in excitement because of a phenomenon of successive induction. At the same time the point previously excited and connected with the movement of withdrawal from the food becomes inhibited. Thus a movement of the dog toward the food occurs. Pavlov explains in a similar way the negativism of the catatonic.

The use of the words *hypnosis* and *functional* had led some to believe that Pavlov considered schizophrenia a functional disease. However, as he remarked during a lesson given at one of his regular Wednesday lectures (December 12, 1934), and as Rochlin later

clarified, Pavlov considered schizophrenia a functional disease only in the initial stages. Later the functional condition would become organic. A specific autointoxication might be at the bottom of the disorder. Pavlov also thought that the inhibition of the cerebral cortex may determine a disinhibition of the brain stem, which is no longer under cortical control.

In an open letter to Pierre Janet, Pavlov (1933a) described his concepts of delusional ideas, based on the notion of the contrary. Pavlov wrote that the notion of the contrary is a fundamental one in normal thinking. In delusional thinking the category of contrary is altered. The right thought and the positive affirmation are blocked; the opposite thought, which is false, instead of being excluded, starts to prevail. What should be inhibited becomes stimulated, and what should be stimulated becomes inhibited. According to Pavlov this reaction is due to "an ultraparadoxical hypnotic phase" and is at the basis of paranoiac-paranoid thinking and of schizophrenic ambivalence. In another article Pavlov (1933b) tried to explain in the same way the obsessions of the neurotic and the thinking of the paranoiac-paranoid, inasmuch as all these symptoms have the tendency to persist. According to him these symptoms are caused by

pathological inertia of excitement of small areas of the brain. Some cortical islets would continue to remain abnormally excited and would be responsible for the persistance of the symptoms.

Among the pupils of Pavlov worthy of mention are: (1) Ivanov-Smolenskij, who demonstrated the difficulty of the catatonic patient to form conditioned reflexes (1934); (2) Protopopov, who, with many studies about conditioned reflexes, believed he had confirmed Pavlov's idea of schizophrenia as a hypnotic state of the cortex (1938); (3) Popov, who did important work, especially on catatonics (1957).

The Existentialistic School

Schizophrenia has received much attention from followers of the phenomenological-existentialistic school of psychiatry, especially in German-speaking countries, but also in France, Italy, and Japan. There is no definite phenomenological-existentialistic theory of schizophrenia, but special orientations or attitudes, which, although varying from author to author, can all be included in the phenomenological-existentialistic literature. Such people as Binswanger, Minkowski, and Boss have diversities of view that are no

less important than what they have in common.

Binswanger is perhaps the best-known psychiatrist of this group. He devoted four large works to the study of schizophrenia, which consist of the detailed existentialistic analysis of four patients to whom he gave the names Lola Voss, Use, Ellen West, and Suzanne Urban. These works have become classics for students of existential psychiatry (1949, 1957, 1958a, *b).*

In the reports of these cases Binswanger was interested not in constitutional or psychodynamic or symbolic or characterologic studies of the patient but in the underlying *structure* that existed prior to the illness. This structure explains the way of being-in-the-world of the patient, his pathologic potentialities, and the uniqueness of his experiences.

Binswanger tried to explain the delusional world of the patient as the evolving of a theme—terror, for instance, in the case of Suzanne Urban, who is the prisoner of her own theme of terror and who becomes the prisoner of a world of terror. The theme in the case of Ellen West is fear of filling the body and becoming fat in order to

compensate for an empty existence. Undoubtedly these studies enrich our understanding of the schizophrenic patient and will be useful, provided they are complemented by the psychodynamic, formal, and psychosomatic studies.

The patients that Binswanger selected for demonstration, although seriously ill, disclosed a preservation of their personality and no signs of regression. Thus the general theme of this delusional world could reveal itself to the author's analysis with not too much difficulty. Other psychiatrists might consider these patients cases of paranoia or paranoid conditions. In the case of Ellen West there is a strong possibility that the case is one of anorexia nervosa and not of schizophrenia.

Minkowski, a pupil of Bleuler, added to Bleuler's conceptions the flavor of Husserl's and Bergson's philosophies. In his major work, *La Schizophrenic* (1953), he stated that the crucial point of the schizophrenic syndrome is "the loss of vital contact with reality." He also added that such contact can be reestablished as a result of therapy, but he did not give instructions on how to reestablish such contact. In other studies he focused his attention on the alteration of

the sense of time and space in schizophrenics. Whereas space expands to include the whole category of the objects that are involved in the patient's delusions, time is blocked and limited to the present.

In a later study Minkowski (1966) stated that the function of unreality is as important as the function of reality. Man can be at fault for excessive realism as well as for excessive unrealism. We need to escape from the hard reality and resort to our imagination. The human being may be in deep contact with reality, for instance, in the state of contemplation. He may also detach himself from reality, as in reflection and meditation. Whereas the imagination of the normal is within the limit of reality, the imagination of the sick undergoes *"une rupture morbide du contact avec la realite."* Minkowski searched for the central unifying experience in the life of his patient and tried to orient the person around this experience. This experience gives meanings and structures to one's life.

Boss is a Swiss psychiatrist who has tried to reconcile psychoanalysis with existentialism (1963). According to him, the way of existence of the psychotic patient is different from that of the normal or of the neurotic. We call some experiences "hallucinatory"

and “delusional,” but rather than use these terms, which have a derogatory meaning, we should call them different ways of encountering the world. In the schizophrenic experience there is a deconstriction, a new way of discovering phenomena and of relating to them. Thus a patient who had undergone a setback in being badly disappointed by a friend started to represent the sun intellectually as something that was for him as important as the only friendship he had in life. Soon the thought of the sun became a hallucination of the sun itself, which he saw in his room, on the wall, during the night (Boss, 1973).

The Australian psychologist MacNab (1966) also interprets schizophrenia from a predominantly existentialistic point of view. He adopts Kierkegaard’s view that objective reason should not be identified with reality. The therapist must understand the patient’s being-in-the-world; must see the world through the patient’s eyes. Although schizophrenia is an estrangement, a special mode of being, an unusual way of making decisions, it is predominantly “a loss of the Determining Center.” MacNab follows Paul Tillich, according to whom a man who does not find his “Determining Center” in God despairs in his quest for courage to be. “In the schizophrenic the loss of courage

devastates his whole being."

Schizotaxia and Schizophrenia

In his presidential address to the Seventieth Annual Convention of the American Psychological Association, held in St. Louis on September 2, 1962, Meehl advanced his theory of schizophrenia (1962). According to him some persons, whom he calls schizotypic, present four main characteristics: cognitive slippage, interpersonal aversiveness, anhedonia, and ambivalence. They are indications of a neural integrative defect, which Meehl calls *schizotaxia.* The four core behavior traits are not innate; they are learned by people with this integrative defect, in some predisposing environmental situations.

All schizotaxics become schizotypic in personality organization, but most of them do not decompensate and never develop a psychosis. A minority of schizotaxics who happen to have other constitutional weaknesses and schizophrenogenic mothers (most of whom are themselves schizotypes) are "potentiated into clinical schizophrenia." In other words, schizotaxia is a necessary but not sufficient condition in the etiology of schizophrenia. Meehl believes that a nonschizotaxic

individual, whatever his other genetic potentiality and whatever his life experiences, would not become a schizotype and therefore would not become a schizophrenic. Even in the most adverse circumstances he would develop a character disorder or a psychoneurosis rather than schizophrenia.

According to Meehl the neurological defect underlying schizotaxia probably resides in the neuron's synaptic control function. Meehl borrows the concept of anhedonia from Rado, to whom we have already referred in this book. The characteristic ambivalence, which originated with Bleuler, has since been found not to be specific to any psychiatric condition. Interpersonal aversiveness is social fear or expectation of rejection. Meehl stresses cognitive slippage in preschizophrenics and in parents of schizophrenics, but cognitive slippage is common in all kinds of seriously disturbed people. Meehl correctly states that the increased interest in interpersonal *dynamics* has made people underestimate the importance of cognition in the field of schizophrenia.

III
Concluding Remarks

In this third and final section I cannot adequately summarize all the ideas that I have expressed in forty-five chapters. I feel that a well-organized outline would not do justice to the complexity of the problems that have been studied. Instead, I shall allow some ideas to emerge spontaneously as recurring themes do, or themes that want to be expressed once more, because they are deeply felt and want to be heard again in a slightly different formulation.

I believe that the concept of schizophrenia is useful and should be retained when applied to a particular psychological dysfunction of the human being that manifests itself in many varieties. The disability is real, and in almost all cases painful and harmful. The dysfunction can therefore be included in the medical model, provided this model is enlarged to comprehend those biological functions that are called psychological and are partially related to the social environment. To adhere to a medical model which followed Virchow's tenets and which was formulated before psychiatry had gained full consideration as a science, would be like following in physics a Euclidian-Newtonian system after Einstein and Heisenberg had conceived a more inclusive one.

Schizophrenia is an abnormal way of dealing with an extreme state of anxiety, which originated in childhood and was reactivated later on in life by psychological factors. It is an abnormal state inasmuch as it uses a category of specific mechanisms which belong to lower levels of integration and ordinarily play a much less prominent role in life.

What is the cause of schizophrenia? When we contemplate the fact that the average incidence of the disorder in the general population is less than 1 percent, but the concordance in monozygotic twins, even if reared apart, although variously estimated, is many times greater, we must conclude that a genetic factor plays a role. This role, however, does not explain the problem in its entirety. Otherwise the concordance in monozygotic twins would be 100 percent. What is transmitted is only a potentiality, which is transformed into clinical actuality by special circumstances of life. These circumstances of life originate in the family environment.

Perhaps the parent has a disturbed but not psychotic variety of personality that is linked biologically with being a carrier of the genetic potentiality of the disorder. Perhaps the personality of the

parent is completely dissociated from any genetic factor. In either case the future patient grows in a psychologically unhealthy environment. The psychopathology occurring early in life is the result of an interplay between interpersonal and intrapsychic mechanisms. This early pathology is of crucial importance, inasmuch as it narrows the range of choices of life directions, determines basic orientations, thwarts the possibility of compensation, and facilitates abnormal sequence of events. Life patterns that may lead to the disorder start to emerge.

I have divided the life cycle of the patient into four periods, the last of which is the psychotic. Many authors see a continuity between the family disturbance and the state of the patient in his prepsychotic periods and finally in the psychotic. Since my early studies in the 1940s, I too have seen this psychodynamic continuity. However, in disagreement with the authors whose writings I have discussed in Chapters 5 and 8, within the framework of this continuity I see also a discontinuity that is equally important for a psychodynamic, psychopathological in general, and psychotherapeutic understanding. The mentioned authors believe that the family members transmit directly to the child, or teach him, irrational patterns of thinking, the same irrationality that is later manifested in the schizophrenic

disorder. Because the child does not have at his disposal adequate models for identifications, he does not have the instrumental equipment for growing in a mature way.

In Part Two of this book I have shown that the child does not absorb passively this family pathology and irrationality, but that he too adds his own contribution to a pathological complex. His genetic characteristics either make him particularly sensitive and vulnerable to painful situations or elicit in him an abnormal use of maladaptive primary process mechanisms. Other factors caused by the psychological environment or by the timing or sequence of events play a role. So do sociocultural factors by acting on the parents or on the child himself. Vicious circles that consist of partially interpersonal and partially intrapsychic processes repeat themselves, accrue, and prolong a course that leads to schizophrenia, but not ineluctably. The direction can always be diverted at any period. Defenses are always built against the injury to the inner self.

During the first period the environmental pathology is not directly absorbed or mirrored by the child but distorted, magnified, and internalized in discontinuous ways. Not only do the self-image and

the mother-image in most cases become grotesque representations of reality, but the same thing happens to the image of the other, any person other than the self, who comes to be experienced as a stranger, removed from bonds of human solidarity, and possibly the carrier of inimical power. The child will develop an actual or potential abnormal fear of the self, the other, life, the world.

During the second period (grammar school) the child develops as defenses prepsychotic types of personality, the most common of which are the schizoid and the stormy. Massive repression of experiences and the formation of the prepsychotic personality permit a compromise with the environment, but not a condition of basic trust or a normal dialogue with the family or a state of relatedness with the interpersonal world.

During the third period (adolescence and youth) the defenses start to be less effective. The patient finds himself in "a jungle of concepts," which attack from all sides his inner image, his inner self. He undergoes a preschizophrenic panic during which what is repressed and archaic and what is conscious and present reinforce each other and inflict a fatal blow. The psychosis, in its various types,

ensues.

It is at the beginning of the fourth, or psychotic, period that a second discontinuity takes place: the break with reality, the adoption of ways not shared by society, the entrance into the world of schizophrenia.

In Part Three I have illustrated in detail the modalities of schizophrenic thought and language, action and will, work and creativity, living symbolically with oneself and others. I have attempted to individualize the basic structures that underlie the psychotic variety of the psychodynamic experience. Both the structural and the psychodynamic approaches have been applied to study the constant coupling and interplay of form and content.

How do we explain the passage from a psychodynamic frame of reference culminating in the defeat of the self to a psychostructural frame of reference that deals with such phenomena as archaic symbolism, paleologic thinking, perceptualization of the concept, concretization of the abstract, impaired volition, and so forth? It seems almost as if we have to merge two logical universes, two irreconcilable

views of man and nature. With the formulation of the principle of progressive teleologic regression, presented in Chapter 15, I have tried to explain what I consider a second discontinuity in the life of the schizophrenic.

Unless the regression is stopped, it proceeds through four different stages, with specific processes described in Part Four. In Part Five, after having reviewed the major somatic studies, I discuss in purely hypothetical terms a third or psychosomatic discontinuity. It is the psychological process itself that may sooner or later bring about a disorganization of neuronal patterns.

Other etiological factors are examined throughout the book, and blueprints for the prevention of schizophrenia are tentatively drawn in Chapter 33.

But I am sure that the reader has grasped what I think is the most important of my conclusions: that even if we do not know the whole complex etiology of the disorder, what we know is a great deal and is sufficient to cure or ameliorate the condition of the majority of people suffering from schizophrenia. Physical therapies help considerably by

making the patient less susceptible, less vulnerable, or less sensitive to the type of anxiety that brings about psychotic symptoms. But psychotherapy, although unable to alter the biological predisposition to the disorder, affects the psychological components that have actualized the genetic potentiality into a clinical syndrome. If we remove their impact, we may remove the disorder.

In this book we have seen that it is not easy to do so, because the psychogenic patterns of living are ingrained in the distant past and the psychotic ways offer alluring secondary gains. Often the patient's remoteness looms unconquerable, and our offer of warmth rekindles his terror. But in this book I have also tried to show how in most cases the therapist can help the patient to experience the human tie more intensely than any fear, more strongly than any need for distance. To the extent that I have failed, I hope I have at least encouraged others to further this arduous task. To the extent that I have succeeded, I have helped those dedicated to relieve the sufferer. I also hope that by showing that we can learn and practice the ways of bringing trust to the distrustful, clarity to the bewildered, speech to the mute, creativity to the grotesque, confident expectation to the hopeless, and companionship to the lonely, I have suggested a larger vista for the

human horizon, a larger use for the human bond, and optimism for the solution of those other conditions in health or illness that, although difficult, are not so obscure, so hard to approach, so desperate, so far from the usual reach of man's words and care.

When the person who had the habit of staring vacantly, almost into space, because he felt the world was not to be perceived, focuses on the many little things of life and recognizes sparks here and there and sees again the sun and the stars and the new leaves and hears the rustling of the branches and the children's laughter and the neighbors' greetings and the joyful noises of the street and craves for what tomorrow will bring, then we believe in greater realizations, then we envision with faith the universality of the human embrace.

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