Abstract

Data are presented in support of an understanding of schizophrenic and paranoid processes as operating relatively independently in the formation and deformation of human personality. The schizophrenic process derives from a genetically determined diathesis in combination with a range of factors involving environmental stress. The effects of the schizophrenic process in the organization and integration of internal structure and the differentiation of psychic functions are found at multiple levels, including negative consequences for the integration between cognitive and affective capacities, between conceptual and perceptual functions, and in the integration and stabilization of psychic structures. The schizophrenic process is envisioned as having disorganizing and disruptive effects on different levels of psychic organization, including the levels of the organization of cognitive processes, the formation and integration of representational systems (both self and object), and the structural integration of the self-system. In contrast, the paranoid process is thought to operate in the shaping and internal patterning of the personality organization, particularly by way of crucial forms of internalization. The interaction of introjection and projection shapes the individual’s self-organization and contributes to the quality of interaction with significant objects. The impact of the paranoid process in both its positive function of contributing to the building up and integration of a meaningful and constructive sense of self and capacity for psychological functioning, as well as its deviant forms of expression in the development of paranoid pathology, is discussed. Although the schizophrenic and paranoid processes operate relatively independently, their interaction and intermingling contributes to the spectrum of forms of psychopathology that characterize the schizophrenic spectrum.

Almost from the beginning of attempts to categorize forms of mental illness, the relationship between the schizophrenic disorders and paranoia has been an uneasy one. The history of psychiatric diagnosis is marked by considerable vacillation among the prominent psychiatric thinkers who attempted to describe these disorders and to gain some diagnostic precision with regard to them. The classic view was formulated by Kraepelin, who viewed pure paranoia as a separate disease from schizophrenia, but one whose occurrence was exceedingly rare. However, Kraepelin also included a paranoid form of schizophrenia as the more frequent and typical expression of paranoid disease. Thus, paranoid schizophrenia was classified as one of the major forms of schizophrenic illness.

Not only has the acceptance of the classical view been uneasy and frequently challenged, but substantial evidence seems to be accumulating to suggest that a sharper diagnostic discrimination between paranoid and schizophrenic illness may be indicated. The basic issue is more than merely descriptive or diagnostic. Be-
yon beyond phenomenology, there lies the question of our basic understanding of the schizophrenic process and the paranoid process. If it can be demonstrated that the divergence between forms of paranoid and schizophrenic illness is sufficiently great, we have grounds to think that these separate forms of disease reflect the differential operation of entirely different underlying psychological processes.

The line of argument I pursue here is that clinical and experimental evidence exists to justify the separate treatment of paranoid illness and paranoid schizophrenic manifestations as different and distinguishable forms of psychopathology. I argue that to understand the underlying forces which contribute to the shaping of these forms of mental disorder, we must conceptualize two processes which operate in varying degrees separately and independently, but also can be found operating in conjunction in many patients.

**Process Perspective**

The Kraepelinae preoccupation with establishing clear-cut diagnostic categories has given way in more recent times to persistent uncertainty. There is an increasing realization that paranoid symptoms express themselves not only in isolated paranoid disease forms, but can also be found in a wide variety of clinical contexts and with varying degrees of intensity in nearly all diagnostic categories (Meissner 1978). These concerns have been with us for some time. Reviewing the concepts of paranoia in 1914, Stanley Abbott commented:

> Symptoms, symptom-pictures, even diseases and disease-processes, are being thrust into the background, while the mechanisms of the origin and development of the content of thinking and feeling, and the interpretation and explanation of symptoms, are coming into the foreground. Make-up or personality and individual experiences assume increased value and importance. [p. 31]

Abbott thus presaged the contemporary shift away from the preoccupations of descriptive psychiatry and toward a deeper concern with the understanding of mechanisms and processes. With the shift in orientation from diagnosis to process, there is also a shift from an orientation toward schizophrenia or paranoia as pathology to a consideration of schizophrenic and paranoid processes as such. The shift to an independent consideration of process characteristics reveals that the processes, as such, can be identified in normal and adaptive psychological functioning as well as in the pathological (see Meissner 1978). Indeed, the paranoid process can be seen to operate in a broad range of normal phenomena and to contribute positively to the sustaining forces in the life experience of normal individuals. Paranoid mechanisms not only can serve to maintain the organization of individual personalities, but can also be thought of as serving important functions in the integration and sustenance of social and cultural processes. Here we can include a variety of belief systems, political ideologies, social and cultural ideologies, and even value systems.

In all of these contexts, identified paranoid mechanisms may be regarded as variant manifestations of the paranoid process. The shift in perspective from a view of paranoia as pathology to a view of paranoia as process carries us beyond the clinical realm to a broad range of social, political, religious, and cultural phenomena, which shape and sustain the life of mankind more generally. Moreover, within this shift in perspective, the paranoid process has relevance not only for the understanding of certain forms of pathological deviation, but as a contributing force to the shaping of normal personality development and functioning. It seems safe to add that our understanding of the paranoid process in multiple and divergent contexts has advanced beyond our current understanding of the schizophrenic process, which remains mysterious.

The notion of process carries with it implications of dynamic change and progression through time. The concept of process itself, however, is not limited to positive progression or positive change any more than to negative progression with its implication of destructive or disorganizing effect. In its positive sense, the concept of process is linked with the notion of progression, particularly the emergence, shaping, and sustaining of structural continuity through time. In contrast, in its negative sense, the concept of process may imply the distortion or destruction of similar structural integrity or continuity.

But in any case, the process perspective cannot be simply reduced to structural terms, since over and above the structural derivatives, the notion of process deals with continuity and progression between structures or correspondingly with the discontinuity and
regressive deterioration between similar structures. Moreover, the process does not take place in a vacuum, but rather is subject to multiple extrinsic influences, positive or negative, into which it must be fitted. Process can be envisioned as involved in complex assimilative and accommodative operations in Piaget's terms with the multiple and complex influences that come to bear on it and influence its patterning. Consequently, the notion of process implies a developmental reference and an adaptational and directive component. The developmental perspective would concern the more inherently positive internal progression and organization of elements, or, correspondingly in the negative frame of reference, the disruption and distortion of such integrating effects. By the same token, the adaptive aspect carries a more explicit reference to the direction, intention, external modification, and fitting in of the process with its environmental influences and effects, or the relative failure of these elements in its negative sense.

The notion of process also is relatively nonspecific in its denotation. The operation of the paranoid process, for example, plays itself out at multiple levels of psychological and social integration. We can describe the operation of the mechanisms which characterize the paranoid process in individual personalities. The description is applicable to deviant forms of pathological expression, which can be found in a variety of forms of psychopathology, but most particularly in paranoid pathology. However, the same mechanisms can be found operating in the genesis of normal personality structure and functioning. The same process is operative in both contexts, so that neither can claim to be the exclusive realm of operation of the paranoid process.

By the same token, these mechanisms can be found to be operating in the psychological substructure of more complex social and cultural phenomena. Here again, the process reference remains nonspecific, so that when we designate the operation of these same mechanisms, we are not dealing with a different form of process but rather a variant manifestation of the same process—now, however, expressing the products of its operation in more far-reaching and complex realms of human involvement. Consequently, the perspective of process in the study of paranoia moves from a rather specific and confined area of consideration—namely, the focusing and definition of a form of pathology—to a much broader and more far-reaching perspective which embraces developmental, adaptive, defensive, functional, social, and cultural phenomena. Whether the understanding of the schizophrenic process can lend itself to a similar broadening and extension is open to question. The answer, in part, depends on our ability to understand and formulate the schizophrenic process, but also depends in significant degree on available evidence for the operation of the process so understood in broader human contexts than the merely and restrictively pathological.

The Diagnostic Dilemma

The starting point for our discussion is the question of the connection or overlap between schizophrenia and paranoia as diagnostic entities: whether paranoia and schizophrenia can be envisioned diagnostically as sufficiently diverse and separable to warrant description as separate diagnostic entities or whether their overlap and linkage is sufficiently great to warrant their consideration under a single diagnostic category.

The problem and the dilemma have a history. While the discussion of the problem of paranoia extends into ancient times and can be found even in the Hippocratic corpus (Lewis 1970), modern history of the understanding of paranoia begins in the 19th century. The term was reintroduced by Heinroth as an affliction that predominantly affected the understanding as opposed to the will or affects. The relationship between paranoia and what we now think of as schizophrenia was considered in the middle of the 19th century by Kahlbaum, who questioned whether paranoia was to be regarded as a persistent and chronic condition in its own right, or should be regarded as one rather late stage that occurred as a secondary feature in a deteriorating course leading to dementia. Kahlbaum tended to reinforce the view of paranoia as a primary delusional condition independent of the so-called vesanias. Thus, Kahlbaum's restriction of the term narrowed it to a delusional condition characterized by persecutory or grandiose thoughts which tended to be relatively stable and did not progress to deterioration of dementia.

The more or less definitive cast to the diagnostic formulation of paranoia and its relationship to schizophrenia was given by...
Kraepelin. Kraepelin followed Kahlbaum’s lead in his early work on the subject, emphasizing the diagnostic delimitation of disease entities relying on an analysis of cause, course, duration, and outcome. Like Kahlbaum, he used the term paranoia restrictively to refer to a chronic, persistent, and incurable delusional condition which arose primarily on a constitutional basis. Kraepelin’s contributions are discussed in considerable detail elsewhere in this issue (Kendler and Tsuang 1981).

It seems clear in retrospect that Kraepelin was greatly troubled by and unable to resolve the question that we are addressing—namely, the degree of conjunction or distinction diagnostically between paranoia and schizophrenia. A major focus of Kraepelin’s orientation to dementia praecox was outcome—whether or not the patient followed a course of deterioration. While observable clinical phenomena, such as hallucinations, delusions, and disordered affect, were helpful in making a diagnosis, the clinician still had to wait for a course of deterioration to develop before establishing a definitive diagnosis. This situation was complicated by the fact that Kraepelin himself recognized that a significant percentage of the cases of dementia praecox did not, in fact, so deteriorate.

The diagnostic impasse thus created was resolved to a certain extent by the work of Bleuler, who discarded the term “dementia praecox” and replaced it with “schizophrenia.” In Bleuler’s view, the relative incurability and terminal deterioration were not essential features of schizophrenia. Bleuler emphasized the organization of symptoms, which he described as either primary or secondary. The primary symptoms included disturbances of affect, association, and volition. Other features of the schizophrenic picture such as hallucinations, delusions, negativism, and apathy, which had been the basis of Kraepelin’s clinical description, were regarded as secondary manifestations of the disease process. He also conceptualized ambivalence and autism as important features of schizophrenia. It is Bleuler’s view that has come to dominate thinking about schizophrenia.

More recent diagnostic usage tends to separate paranoid states and paranoid personality from schizophrenia. True paranoia is regarded as an extremely rare condition marked by systematic and pronounced delusions, which usually have been strongly systematized and do not affect the organization and functioning of other parts of the personality. However, paranoid manifestations can be found not only in psychotic patients, but in the broad spectrum of psychopathology (Meissner 1978). This complicates the differential diagnosis of cases of paranoia. In general, the discrimination between paranoia and paranoid schizophrenic conditions hinges on the degree of preservation of the personality. When the personality structure remains relatively organized and intact in the presence of such delusions, the diagnosis is more likely to be some form of paranoia. Clinicians have generally regarded the delusions of the paranoid patient as better organized—that is, less bizarre, less fragmented, and more in touch with reality—than those of the schizophrenic. Any secondary manifestations—for example, hallucinations, changes in behavior, mood, and thinking—arise from the paranoid patient’s delusional system and can readily be connected with it. These same disorders tend to be primary in the schizophrenic patient and may not have any systematic connection with the delusional system.

Contemporary views vary considerably, reflecting discomfort with the formal diagnostic categories. As the historical dilemmas would suggest, the discrimination between various forms of paranoia and schizophrenia is difficult and problematic. The diagnostic differentiation clinically between paranoid and nonparanoid forms of schizophrenia continues to be an area of unresolved controversy.

**Prognosis**

Generally, the burden of recent studies is that paranoid schizophrenics have less impairment and better prognoses than nonparanoids. The data on the relative prognoses of paranoid vs. nonparanoid schizophrenics have been reviewed elsewhere in this issue (Ritzler 1981). But a few points are worthy of note here. Among process schizophrenics, nonparanoids have been reported to have earlier onset, increased length of hospital stay, greater degree of thought disorder, and a higher incidence of catatonic traits than paranoids (Tsuang et al. 1974). In addition, paranoid schizophrenic patients undergo briefer hospitalizations and experience fewer readmissions than do nonparanoid patients (Strauss, Sirokin, and Grisell 1974). There is, in addition, a considerable amount of study contrasting
the paranoid and hebephrenic subtypes of schizophrenia. The work of Winokur (1975) and Winokur et al. (1974) indicates the following differences: (1) the hebephrenic group is characterized by earlier onset of the disease process, more severe symptoms, and a greater degree of disruption of both social and family relationships than a comparison group of paranoid patients; (2) genetically, the families of hebephrenic patients include three times as many schizophrenic relatives as do those of the paranoids; (3) the schizophrenic relatives of the hebephrenic group are more often themselves hebephrenic than in the paranoid group; (4) by the same token, families of the paranoid group contain more paranoid disorders than do those of the hebephrenic group. The authors conclude that there may be at least two types of process schizophrenia, one basically hebephrenic but occasionally manifesting itself as paranoid schizophrenia, and a second type that is basically paranoid with a low degree of schizophrenic incidence in the family. In addition, the paranoid and hebephrenic subgroups show little diagnostic change over time.

Separation of these subtypes is further supported by findings that hebephrenics show greater changes in affect, higher incidence of tendential thinking, and more frequent blocking and are generally less delusional than paranoids. A number of differentiating factors cannot be explained simply on the basis of diagnostic criteria. The paranoids were found to be older at age of onset and at time of index admission than the hebephrenics. Half as many hebephrenics were married as paranoids, and even fewer had ever had children. The hebephrenics were more excursive and distractible, and showed more frequent defects in memory and orientation, along with a higher incidence of psychomotor symptoms, such as hyperactivity, agitation, pacing, and posturing (Winokur et al. 1974).

Further confirmatory data come from an extensive Scandinavian study of birth cohorts of schizophrenic men. The hebephrenic-catatonic schizophrenic group again showed an earlier age of onset and lower marriage and fertility rates, but also a severely deteriorating course and almost twice as many schizophrenic family members in comparison with the paranoid group (Larson and Nyman 1973).

Additional information comes from the study of the relationship between premorbid status or competence and diagnosis. The first reports of the relationship between premorbid social competence and paranoid-nonparanoid status found that State hospital patients with a better premorbid adjustment were more likely to be diagnosed as paranoid than those with a poor premorbid adjustment (Goldstein, Held, and Cromwell 1968). A subsequent study (Evans, Goldstein, and Rodnick 1973) indicated that paranoid schizophrenic patients more frequently had histories of good premorbid competence, while nonparanoid schizophrenics were equally divided between those having good and those having poor premorbid histories. Nonetheless, using a measure of social competence, Zigler and Levine (1973) were able to substantiate the relationship between paranoid status and premorbid adjustment in a population of State hospital patients, but not in a population drawn from a VA hospital. Further assessment of this question is provided elsewhere in this issue (Ritzler 1981).

While the relationship between premorbid status and diagnosis can be demonstrated and has been repeatedly supported (Neale, Kopfstein, and Levine 1972; Zigler and Levine 1973; Cromwell 1975; Zigler, Levine, and Zigler 1977), one should be cautious of placing too much weight on it. The studies in support of the relationship indicate that samples studied contain a relatively high proportion of poor premorbid paranoids and good premorbid nonparanoids. Consequently, the relationship would seem to be less than robust, and the findings generally complicated by the heterogeneity of patient groups (Zigler, Levine, and Zigler 1976).

Experimental Evidence

Support for the discrimination of paranoid and schizophrenic entities has also come from more experimental studies, particularly those focusing on differences in cognitive style. Using a battery of objective tests of psychomotor speed, cognition, and social perception, Hamlin and Lorr (1971) found that the tests discriminated between groups of normal, neurotic, paranoid schizophrenic, and nonparanoid schizophrenic subjects. Two discriminant function analyses were used, the first based on variables of psychomotor speed, cognitive efficiency, and social content. The second analysis included a larger number of variables, as well as situational and symptom measures. The greater
differentiation found on the second analysis was due primarily to the cognitive contribution. Other measures dropped out—for example, interference of emotional content, insensitivity to common associations, and the inability to interpret facial expression of emotions. The basic differentiation between the groups studied was concluded to be in the area of cognitive deficit; that is, the differences could not be accounted for simply on the basis of bizarre associations, social isolation, or apathetic motivation.

The fact that paranoid schizophrenics tend to be older, to be better integrated, and to have more systematized delusions than nonparanoid schizophrenics suggested that these groups might be distinguishable by mechanisms of perceptual scanning and cognitive style.

Comparison of a group of paranoids with a group of paranoid schizophrenic patients on tests of visual scanning (Rod-and-Frame Test, Size Estimation Test) revealed that the groups showed little difference on either of these measures, indicating that visual scanning capacity and perceptual field articulation were similar in both groups. While the schizophrenic patients were somewhat more disorganized, the paranoid process seemed to operate in both groups in an equivalent manner, at least as far as perceptual functioning was concerned. Thus, both paranoids and paranoid schizophrenics used similar modes of perceptual functioning and had similar perceptual styles (Tarter and Perley 1975).

Using a sentence verification test, Neufeld (1978) compared the performance of groups of paranoid and nonparanoid schizophrenics with that of normal controls. The test allowed comparison of time lapse for operations of central scanning and comparison with operations associated with response selection and execution. The schizophrenic groups did not differ significantly from normals in latencies regarding noncentral aspects of processing (response selection and response execution), but did show a marked increase in latency measures for both central scanning and comparison. The results were compared to those of a previous study (Neufeld 1977) of comparable groups which also included sentence encoding time. In that study, the sentence and the referent picture were presented simultaneously at the beginning of each trial and remained in the subject’s view until the response was given. The lower rate of sentence representation in the schizophrenic groups appeared to be responsible for the differences observed. Thus, the findings are consistent with the view that a retarded rate of central processing is the primary source of cognitive deficit in schizophrenic patients and that the more global symptoms of thought disorder are secondary manifestations of this underlying deficit. It is worth noting in these studies that when sentence encoding time was included, the paranoid schizophrenic group showed a greater response latency than the nonparanoid.

Additional studies have emphasized the cognitive differentiation between paranoid and nonparanoid schizophrenics. The work of Magaro and his associates has been particularly useful. Using ambiguous slides of common objects in a visual discrimination task, Ross and Magaro (1976) were able to discriminate between the responses of paranoid schizophrenics and nonparanoid schizophrenics: the paranoids followed dominant conceptual cues to a greater extent than did the nonparanoids and controls, even when these cues hindered successful performance of the task. Also, paranoids had more difficulty in changing the cues responded to even when such a change was indicated for test success. As a result, the paranoid group tended to give more inappropriate responses when such dominant conceptual cues hindered rather than helped in the performance of the task.

Studies of field dependency likewise showed differences (Franco and Magaro 1977) consistent with the general view that field-independent subjects tend to have a more theoretical orientation and to be more socially detached (Witkin et al. 1954). This discrimination again would reinforce the conceptual-perceptual discrimination between paranoids and nonparanoids.

As we have seen, there is considerable agreement, particularly among dynamically oriented psychiatrists, that schizophrenia and paranoia are separate disorders with different characteristic course, onset, prognosis, premorbid history, and dynamics. The distinguishing characteristic that is usually emphasized is the level of integration, with the paranoid being seen as developmentally further advanced than the nonparanoid patient (Foulds and Owen 1963).

Much of the empirical research on the cognitive differences between paranoid and nonparanoid schizophrenics has been summa-
rized in a recent book by Magaro (1980). I shall select and summarize some of his conclusions insofar as they have reference to the present discussion. For example, various studies of symptom ratings using factor-analytic techniques seem to indicate that discriminable factors can be attributed, respectively, to paranoid, nonparanoid, and affective conditions. Paranoid factors have been identified as hostile belligerence, paranoid projection, and grandiose expansiveness. Nonparanoid factors include conceptual disorientation and perceptual distortion. The work of Lorr, Klett, and Cave (1967) demonstrates two factors associated with paranoid symptoms. The first is a paranoid process factor which includes ideas of reference, delusions of persecution, conspiracy control and body destruction, ideas of grandiosity, and perceptual distortions including auditory, olfactory, and kinesthetic hallucinations. The second is a hostile paranoid factor which includes perceptual distortions and verbal expressions of belligerence. Such factor-analytic studies demonstrate that paranoid patients differ from schizophrenics insofar as they are less confused and withdrawn, more openly hostile, and more likely to experience delusions. In contrast, nonparanoid symptoms tend to take the form of disorganized movement, bizarre motivation, and disordered thinking. The differences can be characterized as disorganization in the nonparanoid syndromes and hyperorganization in the paranoid.

Similar differences are identifiable on psychodiagnostic tests. On the Rorschach, for example, paranoids give less frequent color responses and show better form-level, organization, and field articulation than do nonparanoids. On tests like the Wechsler Adult Intelligence Scale, paranoids generally show better intellectual functioning. Test data, therefore, suggest that paranoid conceptual capacity is better preserved, personality integration is more developed, and perceptual field is better differentiated than in nonparanoid schizophrenic comparison groups. As Magaro (1980) notes, nonparanoids often seem to be confused or unmotivated to organize stimulus input sufficiently to be able to react to it effectively, and they thus display a global approach that is marked by a general conceptual deficit. In general, on measures of cognitive and psychological functioning, the paranoid group of schizophrenic patients tends to fall closer to the level of normal functioning than do comparable nonparanoid groups.

One of the first cognitive characteristics of schizophrenic patients to be extensively studied was overinclusion. Cameron's (1951, 1959) early contributions in this regard were concerned primarily with paranoid pathology. Later studies have tended to confirm that overinclusion is unique to delusional (paranoid) schizophrenics, although some studies may have been contaminated by the presence of manic patients in the delusional groups. The tendency of manics to show a high degree of overinclusiveness, even higher than schizophrenics, has been demonstrated in several studies (Andreasen and Powers 1974; Munschauer 1976). There is also some suggestion that overinclusion is related to the degree of psychiatric pathology rather than to schizophrenia or paranoia as such (Harrow et al. 1972, 1973). Thus, conceptual overinclusion seems to be related to the degree of idiosyncratic thinking, a more general dimension of psychopathology. The more pathological the paranoid, the more inclusive he is, the greater degree of thought disturbance he manifests, and the closer he comes to similarity to the schizophrenic condition.

Other studies have focused on the differences in levels of conceptual and perceptual functioning in paranoid and nonparanoid schizophrenic patients. McDowell, Reynolds, and Magaro (1979), using a sentence completion task in which sentences of high- or low-probability completion were employed, found that paranoids were able to identify the masked word more accurately than nonparanoids when the task performance depended on conceptual processes—that is, when expectation of a probable ending was high. When improbable endings were used, however, the performance levels tended to reverse, with the nonparanoid group doing better than the paranoid. Signal detection analysis showed that paranoids were biased toward high-probability responses, while the nonparanoids were biased toward low-probability responses. The authors relate these findings to the difference in cognitive emphasis between the paranoid dependence on conceptual elements and the nonparanoid dependence on perceptual elements. Where the expectation of a probable ending is high (cognitive factor), paranoid performance is maximal; where a lack of such expectation makes the performance depend on a more accurate discrimination of an ambig-
uous signal (perceptual factor), nonparanoid performance is correspondingly improved.

The data are used as a basis for comparison to the theory (of Chapman and Chapman, 1973). Their theory suggests that schizophrenics exaggerate the normal response bias so that they can be expected to make more of the most frequent errors made by normals on any given task. This seems to describe the paranoid performance quite well in that paranoids are much more strongly biased than normals in the direction of the high-probability response. The theory, however, does not describe nonparanoid performance. These patients did not make more high-probability response errors than normals, but made almost double the number of total errors and nearly six times the number of low-probability errors. These results were the opposite of those predicted by the Chapmans’ theory (McDowell, Reynolds, and Magaro, 1975).

Consequently, the paranoid style of attributing meaning according to relatively rigid conceptual expectations can operate adaptively when such an expectation is justified, but may be quite maladaptive when it is not. In his work on reaction time experiments, David Shakow (1962) noted what he called the paranoid’s difficulty in forming a segmental set. The inherent rigidity of the paranoid conceptual orientation impedes his capacity to modify his set in any flexible or adaptive manner. As Magaro (1980) notes, delusions may be seen as extreme examples of set rigidity which serve to recast low-probability events in terms of high-probability expectations. The corresponding lack of validation is the mark of deviance.

Magaro (1980) relates findings of differences in cognitive style between paranoid and nonparanoid schizophrenic patients to his integration theory. In this theory, paranoids function with inadequate input, reference to, and integration of perceptual data. In cognitive terms, then, the paranoid has difficulty with the encoding of information from perceptual processes. By contrast, the schizophrenic deficit falls in the realm of conceptual processes. For the paranoid, situations requiring flexible cognitive schemata create difficulty because of his inability to take into account the sensory contexts of incoming stimuli. This can prove maladaptive when a flexibility of conceptualization is required. In the same context, the schizophrenic focuses on sensory aspects of stimuli to the defect of conceptual categorization. Thus, the paranoid’s conceptual rigidity and lack of flexibility is contrasted with the excessive fluidity and lack of stable conceptual organization of the schizophrenic. Obviously, adequate adaptation in a variety of environmental contexts requires optimal functioning and integration of cognitive processes on both the perceptual and conceptual levels.

Thus, although forms of paranoid pathology and schizophrenia share certain pathological characteristics when stated in relatively general and clinical terms, there seems to be ample evidence, as the above selective review suggests, for their separation on empirical, functional, and cognitive grounds.

The thesis of the present article is that there are two separate, discriminable processes that may express themselves infrequently in extreme expression of a continuum of psychopathology, but in great measure may be found in an intersecting and interacting manner in a broad range of pathological conditions. Thus, the distribution of cases in the various diagnostic categories may be a factor of the nature of the processes involved. True paranoia is quite rare, if it exists at all. The relevant question is whether it is possible to have conceptual rigidity and underreliance on perceptual input, while maintaining perceptual integrity and an unimpaired capacity for perceptual intake and encoding.

At the opposite end of the spectrum, we are confronted by a condition or conditions in which the capacity for adaptation is based almost exclusively on current perceptual input with little conceptual processing. The extent to which such a situation can occur may be quite limited, as reflected by the small number of patients who show a chronic schizophrenic deficit without some degree of delusion formation, even though the delusions themselves may be relatively disorganized or transient. The intermediate realm of the schizophrenia spectrum, then, would reflect the intersection of these independent processes—the schizophrenic process and the paranoid process. The varying expressions of symptomatology within this range of patients reflect the varying emphases, respectively, on conceptual and perceptual processes in the integration of experience and in the process of adaptation to environmental input.
The Schizophrenic Process

An important aspect of the understanding of the schizophrenic process is the notion of schizophrenia, not as a univocally conceived static category or entity, but rather as a spectrum of disorders showing certain common characteristics. Reich (1976) has described the spectrum concept as follows:

It designates a theory which maintains that there exists a cluster or spectrum of psychopathological states, some characterized by psychosis and others not, which share a genetic etiology with schizophrenia—and which, therefore, constitute, together with classical schizophrenia itself, a “spectrum of schizophrenic disorders.” [p. 3]

Consequently, within the schizophrenic spectrum, the schizophrenic process may be operating with varying degrees of intensity, with varying degrees of pathological expression ranging from the psychotic to the nonpsychotic, and with a wide variety of pathological outcomes and manifestations. Contained within the broad range of symptomatic expression is the core vulnerability and deficit that relates them to the schizophrenic process, which itself is ultimately linked to a genetic diathesis that is a necessary element in the development of the spectrum diseases. Moreover, the development of any of the classifiable entities within the spectrum would depend on the interaction of environmental stress of various kinds with the genetic diathesis in varying degrees of hereditary-environmental interaction.

This understanding of the schizophrenic process—that not all of its symptomatic or diagnostic expressions are psychotic—is particularly important in our attempts to understand borderline disorders. Certain of the identifiable conditions within the borderline spectrum manifest characteristics which suggest that they share in the schizophrenic or related psychotic processes (Meissner, in press a and in press b). This potential linkage with the schizophrenic process suggests that these borderline conditions may be the result of a significant genetic diathesis (Goldstein and Jones 1977; Meissner 1981a).

Another question that must be raised in the consideration of the schizophrenic process is whether it is related to a single defect or multiple defects of varying expression. Etiologic theories abound, but none has mustered sufficient command of the data to be able to assume a dominant position (Weiner 1980). We seem to be faced with the conundrum of multiple etiologies. There is little argument that we are dealing with a genetic diathesis, probably with variable penetrance. The genetic defect may have determinative and specifiable biochemical, physiological, and/or neuroanatomical correlates. Yet, even if the mystery of the role of biological factors in schizophrenia were to be resolved, we would still have the difficult and problematic matter of the connection between such biological vulnerabilities and the patterning of symptoms, behaviors, and course that we know from clinical experience. The schizophrenic process expresses itself in clinical, behavioral, phenomenological, and psychological terms, and it is this aspect of the problem that we are addressing here.

Attempts to describe the cognitive aspects of the schizophrenic process relate to our previous discussion of the role of conceptual and neurotic deficit in schizophrenia (Magaro 1980). Broen and Storms (1966) have described the schizophrenic deficit as a partial randomization of response hierarchies. According to this theory, the level of response organization is a function of the response-strength ceiling. A low ceiling will lead to disorganization of the response hierarchy under low levels of arousal. However, the same disorganized behavior can occur at different arousal levels in different persons, so that a specific level of arousal cannot be assumed to be related to a specific degree of disorganization of response hierarchies. Thus, schizophrenic disorganization cannot be taken to reflect the same degree of arousal in all patients.

The above theory is clearly related to the previously discussed integration theory in which the specific schizophrenic cognitive defects lies in the area of conceptual capacity. This also accounts for the deviant quality of schizophrenic associations. An increased level of arousal, correlated with levels of anxiety, produces a partial equalization of the response strengths of alternate associations and leads to a relative instability in associative patterns. The associative instability in schizophrenics increases under stress, and this increase is much greater than that found in normals or neurotics. The effect on schizophrenics reflects a greater degree of arousal reactivity to stress conditions or a lower level of response-strength ceiling. This describes the frequently observed disorganization of schizophrenic...
increased arousal may also result in a conceptual deviation in schizophrenics that has been described as either overexclusion or overinclusion. Thus, Broen and Storms (1966) argue that if competing response tendencies include certain inappropriate objects on the one hand or to exclude certain appropriate objects on the other are both operative, the increase in level of arousal may correspondingly increase both types of conceptual errors. As noted above, these forms of conceptual error have been frequently noted in the behavior of schizophrenics, with a more recent emphasis on overinclusion. The phenomenon of overinclusion is more specifically characteristic of paranoid patients. And in at least some experimental contexts the nonparanoid patients demonstrate an opposite tendency. Under such conditions, we can expect delusions to be relatively transitory and unstructured and to be accompanied by the usual disorders of association and conceptualization. When the conceptual categorizations tend to be both under- and overinclusive, it can be assumed that some of the relevant data to a conclusion will be excluded and other loosely associated data, which would normally be regarded as unimportant, will assume an increased degree of relevancy. The delusions will remain transitory and unstructured insofar as the underlying process involves a continual vacillation between competing associations. However, in paranoid conditions the delusional system may be quite stable and even rigid. This may reflect a lowering of the anxiety level such that the arousal and response-strength ceiling effects are not called into play (Broen and Storms 1966).

This disorganization of the hierarchical ordering of competing response tendencies is characteristic of most schizophrenics. Where more than one alternative response tendency may be evoked, normals usually show a hierarchically ordered set of response tendencies, with the more appropriate responses clearly dominant. For the schizophrenic, however, the probability of such alternate responses becomes more nearly equivalent, and the interference from competing responses is increased. Consequently, overinclusive thinking may reflect a more fundamental process by which possible associations to a given stimulus word compete on a more equal basis, reflecting the defects of response disorganization. Correspondingly, competing attention tendencies would be less organized and, as a result, attention in schizophrenics would tend to be more scattered and distractible. In the response to a given stimulus, then, the schizophrenic seems to be limited in his capacity to select out the relevant cues. Among the multiple possibilities for response, he is unable to free himself from the irrelevant.

It should be noted that in some schizophrenics, particularly the nonparanoid chronic group, this tendency is modified by a strategy of reducing interfering responses by a reduction of the field of observation. The reduction of stimulus input is one strategy for dealing with disorganization due to response interference, but its utility would be limited to patients for whom reduced vigilance is an acceptable alternative. Reduction in observation is, therefore, not characteristic of paranoid patients who tend to be less disorganized to begin with, but who are also less comfortable with reduced surveillance of sensory input. Thus, chronic nonparanoid schizophrenics tend to use a subnormal range of stimuli, although the ultimate reasons for this behavior may involve more than merely reduction of attention span.

Broen (1966) summarizes these observations as follows: (1) when there is a single dominant relevant stimulus eliciting multiple response tendencies, normals and schizophrenics tend to have similar dominant and competing responses, but schizophrenics will show a greater degree of disorganized variation among these responses; (2) when multiple stimulus tasks are involved, acute schizophrenics maintain a nearly normal breadth of observation, but attention hierarchies are less organized than in normals; schizophrenic attention will be abnormally scattered among the observed stimuli and will tend to embrace a greater range of stimuli than that of either normals or chronic schizophrenics; (3) with multiple stimulus tasks, chronic schizophrenics (particularly nonparanoids) observe fewer stimuli than normals or acute schizophrenics. The persistence of abnormal response disorganization in chronic patients contributes to the abnormal variability of their attention, but within the limited stimulus range provided by reduced observation.

Formulations of disorganization of response hierarchies are congruent with earlier discussions of conceptual insufficiency in schizophrenia. Response hierarchies are
dictated by conceptual categories which encode, classify, and rank the variety of stimulus input to bring some degree of organization and order into the ongoing interaction with the environment. Where such conceptual capacities and organization are impaired or lacking, the attentional variable is left without regulation and is thereby subject to an increased degree of variability, instability, and distraction. Consequently, the response hierarchies must be regarded as predominantly conceptual, and the two theories can be regarded as largely equivalent.

Our quest to understand the schizophrenic process can be aided by recent psychoanalytic formulations. London (1973a, 1973b) has described two separate lines of thinking in Freud’s theory of schizophrenia, each of which is represented in contemporary debates. The first, the unitary theory, emphasized the continuity between schizophrenia and the neuroses, both of which are viewed as intrapsychically motivated behaviors determined by instinctual drives and defenses. Within this framework both decathexis and the disturbance in reality contact are regarded as defensively motivated, and transference is considered as fundamentally the same in both schizophrenia and the neuroses. Freud developed the unitary or conflict theory as a way of providing a psychoanalytic account that would embrace both the neuroses and the psychoses. But, as London observes, this theory has failed to provide a satisfactory basis for research into the nature of the schizophrenic process and is more oriented toward the maintenance of a cohesive theory than toward the exploration of unique schizophrenic phenomena.

However, Freud’s second theory, the specific theory, sees schizophrenic phenomena as reflecting unique psychological deficiency states. The psychological deficiency in question London views as primarily a decathexis of the mental representations of objects. Decathexis in this context refers to a basic disturbance in mental representation, and the loss of reality contact is secondary to this primary deficit. Also the capacity for transference in schizophrenics comes to be regarded as limited or nonexistent. In the present state of our knowledge, the ultimate understanding of the schizophrenic process, whether it is essentially a condition of pathological defense or of deficiency, remains unsettled.

London himself opts for a modified version of the specific theory. In place of the much misunderstood term “decathexis,” he suggests the following formulations:

- a disturbance in the capacity to organize memory traces into mental object representations and to sustain mental object representations. . . . It is rooted in developmental factors which are superordinate to the development of instinctual drives, is linked biologically to withdrawal responses, and is regulated by the unpleasure principle. [p. 182]

Thus, the schizophrenic scans his environment for patterns of stimulus organization that would normally be provided by a stable representational system interacting with and integrating itself with the ongoing flow of perceptual experience. Even when sufficient structure is provided by the pattern of stimulus input and the attempt is relatively successful, the integration with reality that results may appear to be adequate and adaptive, but it is relatively inefficient and brittle. The schizophrenic has effectively relied on an organization of stimulus input that is not reinforced by a complex organization of patterns of past experience, which is implicit in a stable representational system. London (1973b) comments:

The environment, being limited by the dimensions of time and space, cannot provide the consistency, the symbolic condensations or the range of patterns afforded by a representational system. When the environmental patterning fails to organize ongoing experience, the chaotic behavioural disturbances characteristic of acute schizophrenia ensue. [p. 183]

The view of schizophrenia as reflecting an underlying psychological deficiency state rather than a form of conflict-based and defensively motivated behavior is more consistent with other contemporary approaches to the study of the schizophrenic process. In this sense, the primary intrapsychic disturbance is in the capacity to organize memory traces into mental object representations and in the ability to sustain these object representations. Thus, schizophrenia is viewed as qualitatively different from the psychoneuroses. This primary disturbance extends to the formation and maintenance of self-representations as well as to object representations. This representational defect limits the capacity to regulate environmental stimulation so that schizophrenics are particularly vulnerable to either insufficient or excessive degrees of stimulation. The disturbance of re-
ality relations is secondary to the intrapsychic deficit and may reveal itself paradoxically in either excessive dependence on the environment and/or excessive interference with reality integration (London 1973b).

Two points about the specific theory should be made: (1) The formulation in respect to a deficiency in the forming and sustaining of mental representations again relates the schizophrenic process to cognitive deficiency states, here more broadly conceived as representations. Hence, failure of representational systems leaves the schizophrenic unable to organize and integrate the flow of perceptual input from the environment, as we have seen in the previous discussion of perceptual-conceptual integration defects and the disorganization of response hierarchies. (2) London's argument, consistent with a current trend in psychoanalytic theorizing, emphasizes representational phenomena. However, it seems to me that the understanding of the schizophrenic process is more far-reaching and profound than might be reflected in merely representational terms. I would agree that the deficiency in the formation and maintenance of self-representation is an important area of disturbance reflecting the influence of the schizophrenic process. But instead of emphasizing the representational components, I would prefer to envision the process in more specifically structural terms—that is, the specific patterns and forms of internalization deficit and structural vulnerability that are involved in the schizophrenic process.

Nonetheless, the debate between advocates of these various models persists, and each has its own consequences for the understanding of the underlying process and for the course of therapeutic intervention. Based on the deficiency model, the treatment aims at repair of the underlying deficit with restoration of internal object representation. Hence, technical measures which are the basis of psychoanalytic work may be not only nontherapeutic and inappropriate, but even antitherapeutic. Such measures as the use of the couch, free association, and therapeutic neutrality may only increase the void of separation and reinforce the sense of object loss. Rather, the therapy will aim at creating and maintaining contact with the patient, working to keep channels of communication open and continually fostering identification with a caring and concerned therapist. As Greenson and Wexler (1969) observe,

Whatever will advance the "real" relationship, at least with disturbed schizophrenic patients, takes precedence over transference considerations and ultimately opens the way for effective interpretive intervention. [p. 37]

In the defensive model based on the view of schizophrenia as a disorder of conflict and as not differing qualitatively from neurosis, the loss of internal representations and the deformation of the ego are regarded as consequences of an active defensive operation warding off intolerable affects. The difference lies in the degree of instinctual regression, the prominence of aggression, and disturbances in both ego and superego functions. Proponents of the defensive view regard psychoanalysis as the treatment of choice and regard therapy based on a deficit model as basically harmful. The danger of such therapies, based on notions of object replacement, is that they ignore the inherent aggressivity and destructiveness of the schizophrenic condition. Thus, the analytic method, which is viewed as harmful by deficiency theorists, is at the same time viewed by conflict theorists as a necessary and indicated approach (Aronson 1977).

A somewhat different approach to the understanding of the schizophrenic process is provided by Grotstein (1977a, 1977b). He redefines schizophrenia as a splitting off of a part of the personality which undergoes a separate course of development. The split-off portion centers around a form of infantile psychosis which consists in the paranoid-schizoid and depressive positions. The paranoid-schizoid position becomes the locus of fixation, which impedes the development of key maturational functions and thus disposes to schizophrenia. Schizophrenia as a core disturbance, then, is a separate part of the personality that is distinguished from psychosis, which is a clinical state to which schizophrenia may predispose or that it may precipitate. In this view psychosis may be treated by a number of modalities, but schizophrenia itself may be responsive only to psychoanalysis as the preferred mode of treatment.

The schizophrenic portion of the personality originates in a constitutionally (genetically) determined, inadequate threshold barrier to incoming stimuli, along with a constitutionally precocious sensitivity to perceptions which predispose the infant from birth to a perceptual catastrophe due to inadequate filtering. The inherent potential for terror in these infants
at risk for schizophrenia remains unbuffered and becomes registered as a nameless dread due to the failure of primal repression. The perceptual emergency precipitates desperate defensive maneuvers in which perceptions and perceptual objects are attacked and the very capacity to perceive such objects is undermined, probably by interfering with the capacity to integrate perceptual inputs. Thus, Grotstein's view reestablishes contact with the vicissitudes of the integration and organization of perceptual input as central to the understanding of the schizophrenic process. However, the ultimate roots of his view of the process derive from Kleinian assumptions about the effects of primitive and unmodified aggression in the undermining of stimulus thresholds. The inevitable consequences of this process are perceptual disorganization and disruption of both the developmentally normal progression in formation of the structure of the self and its correlated self-representations, and in the capacity to conceptually organize and integrate perceptual experience.

The material presented here, admittedly partial and selective, nonetheless points in a relatively consistent direction. The conclusions from several avenues of inquiry point to a general cognitive deficit in the organization of the schizophrenic's intrapsychic experience. On the level of the processing of stimulus input, there seems to be an identifiable disparity in the schizophrenic's capacity to integrate, regulate, and organize the ongoing flow of perceptual experience. This is thought to be due to a conceptual deficiency that is reflected in an inadequacy or limited capacity to organize perceptual material in conceptual categories.

At another level of cognitive organization, the schizophrenic deficit can be seen as an incapacity to organize representational schemata, whether of objects or of the self. It is not clear whether the conceptual incapacity previously described is a byproduct of the inherent incapacity for representational organization and integration, or whether both of these identifiable deficits stem from a further underlying deficiency state. In focusing the nature and the central deficit of the schizophrenic process, as I have previously indicated, I would prefer to place the emphasis on the primacy of the failure in self-organization.

Instead of emphasizing the merely representational aspects of this phenomenon, that is, the incapacity to form and sustain coherent and integrated and well-differentiated self-representations, I would shift the emphasis to a structural frame of reference. In these terms the deficit is specifically a structural deficiency to which the disorganization in self-representations refers and from which it derives (Meissner 1972). The schizophrenic process, then, pertains to a developmental deficit which contributes to a failure to organize, integrate, and stabilize the inherent structures that form the core of the individual's self-organization. Thus, the schizophrenic process impinges particularly and specifically on the patterns of internalization which give rise to particularly pathogenic introjects. It is through the internalization of such introjective configurations and their progressive developmental modification that the rudiments of a sense of self are acquired, integrated, and formed into an integrally functioning personality (Meissner 1979, 1980, 1981b). In this frame of reference, self-representations are secondary manifestations of the underlying self-structure and are derived from them. Consequently, the central deficit lies at the level of structural deficit rather than at the level of secondary representational derivatives.

There is no basis currently available for us to discriminate between such structural deficits as the primary area within which the pathogenetic effects of the schizophrenic process are manifested as opposed to inherent conceptual-perceptual deficits. It is entirely plausible that such cognitive deficits, interacting at the border between the environment and the experiencing individual, reflect the underlying structural deficits. However, by the same token, if one keeps in mind that the nature of structural formations is dependent on internalizations from the very beginning of the individual's infantile experience, and that the quality of such internalizations reflects the patterning of object relationships and the experience of such objects, distortions on the level of the functioning of these cognitive processes may play a role in determining the nature of the crucial internalizations which give rise to psychic structure.

In any case, a plausible case has been made for the multiple impacts of the schizophrenic process on these three levels of psychic organization and functioning, which seem to be so closely allied and interwoven. On the level of the organization of cognitive processes, on the level of the formation and...
integration of self- and object-representational systems, and on the level of structural integration of the self-system, the schizophrenic process seems to exercise a profoundly disturbing and destructive influence. Its effect is to produce states of disorganization and dysfunction which impede the adaptive processing of cognitive inputs and the organization of response capabilities, allow for the defensive distortion and instability of representations, and lay the basis for the introduction of structural impediments, which reflect varying degrees of structural disorganization, discontinuity, instability, and dysfunction.

The Paranoid Process

Three basic constructs can be used to describe the constituent mechanisms that underlie the operational characteristics of the paranoid process: introjections, projections, and the paranoid construction. The introjections, around which the core of the patient's sense of self is organized, along with their relative projections and the cognitive organization of the paranoid construction, constitute the organizing, structuralizing, genetic-adaptive process in which the critical internalization of object relations serves to structure the individual's inner world. At the same time, it provides the basis for his subjectively mediated interaction and responsiveness to specific object relationships in the environment.

The critical introjections form the nucleus of the organization of the patient's self-system; correspondingly, the organization of pathogenic introjects forms the core of the pathology in paranoid patients, which finds its ultimate expression in the paranoid delusional system. An important point to note is that the shift in emphasis to the paranoid process carries with it a refocusing of the pathology of paranoia, shifting from a focus on the paranoid delusional system as the characteristic locus of paranoid pathology, to an emphasis on the pathogenic organization of the introjects which form the core of the patient's sense of self and which provide the basis of his paranoid illness. The patterning of projections around which the patient organizes his interactions with the world is derived from this introjective configuration and expresses in its projective distortions repressed or dissociated elements of the patient's self-system. Finally, the paranoid construction provides an overall cognitive framework within which the patient can organize his projective system into a set of coherent and sustaining beliefs which reinforce and serve to buttress the projective system.

The central mechanism in this process is introjection. The introjections reflect the internalization of elements drawn primarily from the parental figures, but also derived from other object-relationships, such as siblings, relatives, teachers, and other significant adult figures. The primary influence, however, comes from the parents so that the introjective configurations are inherent in the parents' own personality structures. The introjective process takes as its object the self-system of the parents (and the interaction between them), which is itself integrated around the central introjects derived from the previous generation. The introjective process thus obtains a transgenerational aspect whereby the introjective organization of one generation provides the basis of parental projections to the next generation, which are consequent-ly internalized as the introjective core of their personality organization.

Introjections must be distinguished from the more primitive and global incorporations, as well as from the higher-level, more differentiated, secondary process identifications which serve as the basis for positive and constructive integration of healthy and adaptive personality functioning (Meissner 1970, 1971, 1972). Between the level of psychotic incorporation, in which internalization of the object obliterates all differentiation between self and object, and more differentiated identifications, which maintain the differentiation between self and object and acknowledge the separateness and individuality of the object as such, introjections form an intermediate realm of internalization in which the object is internalized. The object becomes part of the subject's inner world, but at the same time retains some connection to the object realm. That is to say, the internalized object never becomes completely the internal possession of the subject, but always retains the potential for objectification, for the creating of an experienced distance between the content of the internalized object and the subjective sense of self; it also retains a capacity for re-externalization or transformation from the realm of self-representations to that of object representations. This inherent quality of object connection of the introject is the basis for its potential for projection. The introject is
the result of the operation of defensive mechanisms because it reflects the inability to tolerate the separateness of the objects of dependence and requires that the objects be internalized as a means of avoiding the threat of separation. Thus, the introject comes to have a set of characteristics and interrelated qualities: it is subject to drive influences in varying degrees, it is defensively organized and maintained, and finally it is susceptible to re-externalization by projection.

Developmentally, the introjective configuration comes about by the internalization of elements provided by the personality organization primarily of the parents. The organization of the introjects consequently reflects elements combined from both parents in characteristic patternings. Most often in family settings where the pathological elements are at work, the patterns which serve as the basis for the pathological organization of the patient’s introjects can be plainly seen at work in the parental relationship. The relationship between these patterns of parent interaction and the organization of the internalized derivatives in the patient’s introjective alignment is quite direct.

The characteristic alignment of the introjects can be expressed in terms of polar forms of organization having to do with both aggression and narcissism. Thus, the aggressive polarities express themselves in terms of aggression versus victimization, while the narcissistic components express themselves as a sense of superiority versus inferiority. It is around one or the other or some combination of these introjective components that the individual structures his sense of self. In terms of the victim introject he sees himself as weak, ineffectual, inadequate, helpless, vulnerable, and victimized. In terms of the aggressor introject he sees himself as strong, powerful, domineering, controlling, hostile, and destructive. In terms of the superior introject, in narcissistic terms, he sees himself as superior, special, privileged, perfect, entitled, and even grandiose. In terms of the inferior introject, which provides the opposite pole to the narcissistic superior introject, he sees himself as inferior, worthless, valueless, shameful, and humiliated. Typically in the paranoid patient the victim introject tends to predominate in the patient’s internal subjectively available sphere, while the aggressive aspects are projected to the outside in the form of hostile and destructive persecutors.

As I have noted, the relationship of such introjective configurations to the patterns of family interaction is quite clear and direct. More often than not, in the family of origin the parents are caught up in a pathological interaction which lives and acts out the aggressor versus victim, and superior versus inferior, patterns. In severely disturbed families in which there is a schizophrenic child, these marital patterns have been described as skewed and schismatic (Lidz, Fleck, and Cornelison 1965). The same patterns, however, of parental imbalance, sadomasochistic interaction, emotional divorce, conflictual undercutting, and tension between the parents provide the rudiments for the organization of aggressive and victimized elements in the patient’s internalization of these object characteristics. Frequently enough in our own culture, the relatively domineering and controlling position of the father has been matched by the self-effacing, self-sacrificing, and relatively devalued and demeaned position of the mother. This imbalance in the parental position vis-à-vis one another can serve as a significant developmental matrix out of which the child internalizes the aggressive and victimized aspects of the parental models. The more intense this overbalancing becomes, the greater the degree of pathology one can infer in the family system and the greater the pathogenic distortion that one can expect to be introduced into the patient’s introjective configuration.

The operation of projection in this context, as we have already suggested, bases itself on the introjective configuration and serves to externalize the implicit, repressed, or dissociated aspects of the introjective organization. The locus of projection is primarily in regard to object relationships, that is, the projective elements are usually attributed to significant emotionally involved objects in the environment. This is clearly the case in paranoid projections in which the original projections are attached to significant others and only later are extended to include other persons in the conspiratorial network. The externalization may also take place in relatively displaced ways as is characteristic in the classic mechanism of phobias. The phobic displacement may take place in regard to nonhuman objects, as was the case in Little Hans, but may also express itself in more diffuse and nonspecific ways as is often found in school phobics or agoraphobics. In these
cases, however, the displaced elements can usually be traced back to a central projective core which involves an object relationship.

We have touched on the vicissitudes of narcissism in the genesis of paranoid pathology. Not only is the introjective configuration organized and structured in narcissistic terms, but the correlative function of projection operates equivalently as a narcissistic defense. In addition, the relevance of the interplay of introjection and projection to the working-through of narcissistic concerns, particularly in the context of development, is reflected in the influence of these elements in the shaping and internal organization of the patient's self. The introjective configuration forms the critical core of internalizations around which the self-system is organized and in terms of which the self takes shape. Similarly, the interplay between introjective and projective aspects of this process provides the matrix within which the child's emerging differentiations between self and objects, self and others take place (Meissner 1974, 1978).

Our understanding of these processes has been clarified considerably by the work of Kohut (1971) in the differentiation of early forms of archaic narcissism. Kohut postulates a parallel course of narcissistic development to the more traditionally conceived instinctual development of object libido. He postulates the early differentiation of a relatively undifferentiated state of primary narcissism into a primary discrimination between the idealized parental imago and, correlatively, the formation of a grandiose self. Both of these early formations result from the child's attempts to preserve the early narcissistic investment which is threatened by the inevitable failings of maternal care.

If we shift our frame of reference to that of the paranoid process, it is immediately apparent that the critical notions involved in the progression of narcissistic development depend on a complex interaction of introjective and projective processes. The original differentiation of the idealized parental imago comes from the projective discrimination and assignment of idealizing narcissistic elements to the object imago. Similarly, the emergence of an archaic narcissistically invested, grandiose self is a function of the primitive and primarily discriminating function of introjection. The further developmental elaboration of both of these components through the vicissitudes of the formation and working-through of the dynamics of self-objects depends on the continuing reworking and interplay of projective and introjective mechanisms. The grandiose self is roughly equivalent to what we have described as the narcissistically superior introject, but the perspective of the paranoid process adds the additional note that the superior (grandiose) introject does not obtain in the intrapsychic economy without its correlative projective and reciprocal related introjective ally, the inferior introject, which expresses the negative component of the same narcissistic cathexes.

The last element in the paranoid process to be discussed is the so-called "paranoid construction." The paranoid construction is a cognitive elaboration which serves the specific function of reinforcing, sustaining, and providing a context within which the projective system of the individual can be maintained. It should be said that the projection does not sustain itself. Of itself the projection is unstable, insecure, defensively motivated, and therefore forms a fragile shell that can be easily cracked. If, however, the patient can provide a meaningful frame of reference within which the projection can be sustained, then the defensive purposes of the projective operation are liable to be better served, and the whole operation of the paranoid process can be usefully consolidated. The paranoid construction can take a variety of forms. Pathologically, it often takes the delusional form seen in paranoid patients of a conviction of a conspiracy that may range from a very small group of two or three individuals to a network of nearly cosmic expanse, depending on the degree of omnipotence and grandiosity operative behind the paranoid process. In its more benign and less pathological forms, however, the paranoid construction can also be manifested in belief and value systems of various kinds, including, as we have suggested, political ideologies, religious belief systems, and social and cultural values.

An important question which pervades this consideration is "What is the paranoid process for?" What is its purpose or function? The answer comes most readily through the consideration of the paranoid construction. Whether in its pathological forms or in its more adaptive forms, the paranoid construction provides a matrix within which the individual can find some sense of purposeful involvement and belonging that gives meaning to his existence.
The paranoid construction serves the important function of stabilizing and lending this matrix of significance to the patient's projections. The projections, however, in their turn, also serve the important function of maintaining the integrity of the patient's sense of self. The projective device serves as a means of removing from the patient's sense of himself elements or aspects which are intolerable, repulsive, or excessively painful.

The paranoid patient presumably is not able to tolerate the hostile, destructive, and omnipotent impulses and wishes which are a part of his psychic makeup. These elements are consequently driven out of consciousness and divorced from his sense of himself, and are externalized and attributed to external individuals or forces. Thus, the patient organizes his sense of self around the victim introject so that the projective elements serve the important function of maintaining and consolidating his adherence to that vulnerable and victimized position. If, at the same time, the paranoid construction allows the patient to fit his perception of persecutory agents into a much larger scheme in which they become the instruments of a far-flung Communist conspiracy to do him in, drive him crazy, damage his reputation, or kill him, then the projections take on meaning and can be meaningfully sustained, and the entire composition can be brought to the service of maintaining the individual's sense of himself as a persecuted, helpless, vulnerable victim.

Thus, in some perverse sense, through the operation of the mechanisms of the paranoid process, the individual achieves a sense of identity, an identity which is disturbed, distorted, and pathological to be sure, but an identity nonetheless. That pathological identity is based on the core victim-introject.

Analogously, we can envision the same mechanisms operating in constructive ways to sustain more positive identity positions. The political idealist who attaches himself with fanatic devotion to a political cause, for example, can see himself and his colleagues as deprived, victimized, and vulnerable to the assaults and manipulations of powerful political enemies. Seeing the conflict in these terms not only lends significant meaning to the individual's political involvement, but also serves to sustain his sense of himself as disadvantaged. Consequently, through attachment and devotion to the cause, such an individual may attain a stable sense of identity, which may enable him to function at a relatively high level.

The mechanisms of paranoia can be compared to those of prejudice. Prejudice is based on an unreasonable judgment made in disregard of important or available facts, so that the perception of these facts or of their importance is overridden by some strong affect which fosters the formation of erroneous associations. This gives rise to errors of judgment and interpretation, which are perpetuated by the influence of the affect. Religious, political, racial, and other prejudices manifest the same underlying process. Other errors of attitude or interpretation which are not motivated by such strong affect may persist and lead to further errors, but they can be fairly easily corrected by sufficient evidence or argument. The prejudice, however, persists and may even expand to include related areas: thus, the antivisitioner may also become an antivaccinationist, believing that all physicians are dedicated to the torture of animals. Overcoming the prejudice requires that the underlying affect be modified.

The relevant point here is that paranoia and prejudice of all degrees are manifestations of the operation of the same basic mechanisms that characterize the paranoid process. Moreover, the intensity or destructiveness connected with the operation of these mechanisms is not a useful discriminating criterion. In fact, depending on circumstances and the interaction of multiple complex determinants, paranoid potentialities can be stirred in the most normal and apparently socially adapted individuals to the point at which bizarre, destructive, and almost psychotic behaviors may result. One need only to remind oneself of the racial prejudices in our own country—the lynchings, burnings, torturings, and other more pervasive and subtle forms of discrimination that have written a sad chapter in our history. These bizarre behaviors have often been performed by otherwise apparently normal and upstanding citizens.

The conclusion that can be drawn from these reflections is that the paranoid mechanisms are not isolated to some pathological segment of the population, but are an inherent part of the personality organization of every human being. From one point of view, the pathological potential of the paranoid process can be aroused given the conjunction of circumstances, contexts, and forces which impinge upon or threaten the narcis-
istic organization and integrity of individual personalities. The operation of the paranoid process, both in its normal-adaptive and in its pathological forms, has as its purpose the maintenance of the integrity and sense of inner cohesion of the self. Consequently, the fixity and sense of conviction and apparent unalterability of paranoid ideas derive not from any extrinsic considerations, but rather from the powerful forces which are set at work and drawn into the service of maintaining the individual sense of self and identity. Thus, prejudicial beliefs and convictions are not motivated by any external evidences or considerations, but rather are driven and maintained by the inner necessity and compulsion to maintain a sense of one's own identity and self-esteem, which are somehow threatened by the acknowledgment and acceptance of another group, whether they be religiously, politically, racially, or sexually different from oneself.

Conclusions

We have considered two psychological processes which operate relatively independently in the formation or deformation of human personality. Both serve as the focus for varying aspects of genetic, physiological, interpersonal, and sociocultural influences. Each has a genetic history and developmental patterning that is unique to the life history of the individual personality in which they operate. The schizophrenic process acts to impede internal structural organization, differentiation, and integration. It has the effect of impeding the progression through normal psychological development in the direction of an integrated and harmoniously functioning personality organization.

The schizophrenic process is precipitated by a genetically determined diathesis of varying degree in combination with an infinite range of factors involving environmental stress. Consequently, individuals who are afflicted with the full potential of the genetic diathesis develop schizophrenic pathology almost regardless of the degree of environmental stress. Individuals whose affliction is less can become schizophrenic as a result of greater degrees of environmental stress and pathogenic interaction with significant others in their environment or through other stress-inducing pathogenic factors. There is no substantial evidence to suggest, nor is there any reason to suspect, that individuals who lack the genetic diathesis and who are subjected to extreme degrees of malignant and stressful influence would develop the disease, however pathogenic those influences might be or pathological the resulting personality organization.

It seems best, at the current state of our knowledge, to envision the effects of the schizophrenic process as being fairly diffuse and affecting multiple levels and aspects of psychic functioning. Thus, the integration of psychic capacities is disorganized at multiple levels and, to the degree that the schizophrenic process is operating, reflects the failure of organization of interrelated capacities and functions. Consequently, there is an identifiable relative disorganization and lack of integration between cognitive and affective capacities, and within cognitive capacities a similar disequilibrium is found between conceptual and perceptual functions. The failure of the formation of well-differentiated and stable psychic structures allows for a failure of personality integration, a high degree of vulnerability to regression, and a need to resort to infantile levels of regressive organization and primitive defenses which interfere with the individual's capacity to respond adaptively to environmental input. Consequently, individuals in whom the schizophrenic process operates in its purest and most malignant form are the most chronically afflicted and regressive schizophrenics.

In contrast, the paranoid process involves certain specifiable mechanisms that have to do with the organization and integration of internal personality structure. The paranoid process operates from the beginning of life to provide, by way of various forms of internalization, the shaping and internal patterning of the personality organization. It is the paranoid process, by means of its interacting process of introjection and projection, that shapes the individual's self-organization and correspondingly contributes to and shapes the quality of the subject's interaction with the significant objects in his environment. Where the paranoid process operates with adequate genetic endowment and with sufficiently good quality in its significant object relationships, the emerging pattern of personality organization can enjoy a relatively normal, healthy, and adaptive course of development leading in the direction of an effective, meaningful, purposeful, and constructive sense of self and capacity for psychological functioning.

However, by the same token,
the paranoid process can have pathological outcome depending on inherent, genetically influenced patterns of instinctual endowment in interaction with the relatively healthy or malignant quality of object relationships during the period of growth and development. To the extent that the developmental experience is excessively colored by ambivalence, the resulting introjective configurations can fail to achieve a full measure of structural coherence and integration and may serve as the basis for internal pathogenic formations that can express themselves in varying forms and degrees of psychopathology.

Such pathogenic outcomes can be readily identified in forms of paranoid pathology. In such cases, the inherent mechanisms and dynamisms of the paranoid process are shunted into the service of maintaining the pathogenic introjects and the corresponding pathological sense of self and self-organization that lies at the heart of the patient's pathology. Projection and the paranoid construction become the vehicles for the organization of a threatening, generally hostile, and pathological view of the world. This view colors the patient's interpersonal relationships and his ability to deal with the world of his experience at the same time that it serves as a buffering resource for the stabilization of personality structures and functions that maintain the patient's capacity to organize and integrate stimulus input in a consistent and realistic way, even though the construction carries within it pathological distortion and malicious intent.

In cases of paranoid schizophrenia or paraphrenia, we can see evidence of the combined effects of the separate processes and their interaction. The undermining of psychic structures and the disorganization of psychic functioning calls into play forces of compensation and reintegration. In the face of the ravages of the schizophrenic process, the paranoid process can be brought into play to provide the patient with a semblance of inner coherence and stability. In a sense, then, the paranoid schizophrenic is willing to pay the price of the sacrifice and distortion of his relationship to the outside world in order to gain some degree of inner organization and internal coherence. Thus, in cases of paranoid schizophrenia we can see the positive integrative and constructive aspects of the paranoid process at work, even within the limiting confines and destructively undermining potential related to the schizophrenic process.

However, from this perspective, it is entirely possible that the forms of true paranoia, which are rare enough to allow some doubt as to the validity of such a diagnosis, may in fact be expressions of the paranoid process in relatively pure culture, expressing itself in its relatively pathological form. One need not think that the pathology in question can only be defensively compensating for an underlying or latent schizophrenic process. The paranoid process on its own terms, given the proper malignant and pathogenic influences, can turn in the direction of pathological expression. Moreover, the expressions of paranoid pathology, reflecting varying degrees of deviation and distortion of the paranoid process, can be found in a broad range of forms of psychopathology, and even in some-what regressive aspects of normal psychological functioning where there is no suspicion and no suggestion of the operation of the schizophrenic process.

When the schizophrenic process itself is identifiably in operation, those patients become paranoid who have preserved a residual capacity for mobilizing the inherent resources of the paranoid process in an effort to modify and counter the ravages of the schizophrenic process. Consequently, such patients must be counted as relatively healthier and as having an inherently greater potential for therapeutic response and recovery. This understanding of the interaction and interplay between the schizophrenic and paranoid processes also has implications for the treatment process. It would suggest, at a minimum, that the optimal resources for correcting, modifying, andcountering the effects of the schizophrenic process lie in the direction of our increasing understanding of and ability to make effective therapeutic use of aspects of the paranoid process.

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