INTERPRETATION OF SCHIZOPHRENIA

Averted Schizophrenia:

Relation between Psychosis and Psychoneurosis

SILVANO ARIETI MD

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Silvano Arieti, M.D.

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In the previous chapters of Part Two we have studied the profound psychodynamic importance of the patient's life history. And yet one is often impressed by the fact that schizophrenia has not occurred in certain individuals in spite of what seemed to the psychiatrist the most unfavorable environmental circumstances. Certainly we cannot dismiss the importance of the genetic components, which in these cases might have had protective values. Nevertheless, the adverse environmental situation itself deserves further study. First of all we have to repeat here what we already mentioned in Chapter 8, that conditions of obvious external danger, as in the case of wars, disasters, or other adversities that affect the collectivity, do not produce the type of anxiety that hurts the inner self and do not in themselves favor schizophrenia. Even extreme poverty, physical illness, or personal tragedies do not necessarily lead to schizophrenogenic conflicts unless they have psychological ramifications that hurt the sense of self. Even homes broken by death, divorce, or desertion may be less destructive than homes where both parents are alive, live together, and always

undermine the child's conception of himself.

After ruling out these cases, many remain where, in spite of situations very destructive to the inner self, schizophrenia has not occurred. We shall use the term *averted schizophrenia* to describe a situation where all the ground seemed to have been prepared psychodynamically for a schizophrenic psychosis, and yet the psychosis never occurred. We shall omit from our present discussion those patients who became acutely ill, were already on the brink of the psychosis or in a state of prepsychotic panic, but escaped the psychosis because of prompt therapeutic intervention. In this chapter we are going to discuss patients in whom a slow psychodynamic development that appeared directed toward a schizophrenic outcome was diverted, arrested, or slowed down.

At times fortunate external circumstances have compensatory or remedial effects valuable enough to prevent the disorder. The presence of a beneficial person may be enough to change the pathogenetic potentiality of the environment. A grandmother, a teacher, a maid, an older sibling, or an aunt may have given the patient enough affection and created enough self-esteem to compensate for

the deficiencies of the parents. At times, some fantasy to which the patient has clung tenaciously may have replaced a good parent. For example, a very neurotic patient that a colleague of mine reported on at a meeting was a child of divorced parents. Until he became an adult, he lived with his mother, who hated him. In childhood he had a fantasy that his father, who had gone to live in a distant part of the country, still loved him. One day the father would come back and rescue him from the distressing situation. Although this fantasy was irrational, at the same time it had a strong reassuring quality that possibly saved the patient from a worse mental disorder. Although it was fundamentally a passive fantasy, in the sense that it gave the feeling of being rescued by another human being, nevertheless it enabled the patient to hope and provided an incentive for helping himself in the present.

The point of the actual value of the fantasy *per se* is debatable. One may ask why the patient was capable of creating such a fantasy. Here again circumstances helped. The paternal grandmother, although not a loving person herself, would often mention the father and his alleged great deeds, with the implication that one day he would come back. Thus the grandmother was not able to give much love, but at

least she gave hope to which the child could cling.

At times, under the influence of a newly made acquaintance or of some cultural ideology, the patient changes his expectations from life, accepts some aims more commensurate with his ability, and therefore avoids traumatic challenges.

At other times, psychosis is avoided by means that are unacceptable or less acceptable to society. For instance, the potential schizophrenic may be accepted by a fringe or asocial group. The acceptance by the group or the diminished demands that life makes because of the adoption of the group's habits may prevent an otherwise unavoidable decompensation. Some women avoid the psychosis by becoming a prostitute, or working in burlesque or in underground criminal groups. In those capacities they find some fulfillment, a role, and feel capable of exerting some power. If they are removed from those occupations, they may become psychotic.

In numerous cases schizophrenia is avoided because the patient succeeds in developing sufficient psychoneurotic defenses (hysterical, phobic, obsessive-compulsive mechanisms, and so on). It is only in this

respect (in that a neurosis may protect from a psychosis) that the idea of an antithesis between psychoneurosis and schizophrenia may be upheld. If the character neurosis or the psychoneurosis does not protect the patient sufficiently, a full-fledged psychosis may follow. There are no intrinsic psychological qualities in psychoneuroses, character neuroses, and psychoses that would make one of these conditions eliminate the other. They are all abnormal compromises that are created to deal with certain distressing factors. If the neurotic compromise is not sufficient, the schizophrenic one may follow. In many cases, however, the neurotic compromise is sufficient. In other cases, which are increasing in number, timely psychiatric treatment prevents the psychosis.

Three case histories will be presented in this chapter. In the first two, the character neurosis and the psychoneurotic symptoms protected the patients from the psychosis, in spite of very adverse early environments. In the third case the psychosis seems to have been averted by treatment only. In the first case one can see that from early life the patient followed a definite psychoneurotic pattern and that the question of schizophrenia never arose. In the other two cases, instead, quasi-schizophrenic manifestations were already in evidence and the

psychosis was averted by a narrow margin.

Louis

Louis came for treatment with the following complaints: ‘ ‘I think I am falling out of love with my wife. I love my wife very much, and yet I feel I am going to desert her or that something will happen which will make me separate from her.” He was overanxious, weepy, trembling, and his voice was unsteady in spite of an effort to control it. He added that these ideas came to him all of a sudden while, in the company of his wife, he was seeing a movie starring Ingrid Bergman. He mentioned also that two years previously he had had a fear that he was going to kill everybody, especially his wife. He was also afraid that his father would die.

The patient was a 37-year-old printer, Jewish, of asthenic constitution, who looked a little older than his age. His father was 65 years old, was born in Europe, and owned a stationery store. The father always had put emphasis on work and education, had been a good provider, but had not spent much time with the children. He was never satisfied. If a child’s grade was 95 at school, he would say, “Even

marks like 100 are made for people." The only time he spent with the children was at the dinner table from five to six o'clock, at which time he would always emphasize school and intellectual accomplishments. He never played with them or showed them any affection.

Louis was extremely afraid of his father. The latter would often beat him on account of his poor scholastic achievements and would say, "You will grow up to be a taxi driver; you will never be a professional man." These words appeared almost prophetic for the patient, who is the only one in the family who did not become a professional man. At the same time that he was afraid of his father, Louis admired him, thought that he was very intelligent, always right, and that his predictions would come true. The father was always worried and anxious and somehow was able to impart his anxiety to Louis. Whereas the father was a tyrant in respect to the children, he was completely submissive toward the mother.

The mother was a rather energetic business woman, who had always been disinterested in the family. She spent most of her time in the store. At four o'clock she would go home to prepare supper for the family, but at five o'clock she would go back to the store and would

return home late at night with her husband. The children were left alone; occasionally one or another of the neighbors was asked to keep an eye on them.

The family consisted of six children, Louis being the second oldest. A sister six years older than Louis was the favored child. She worked hard in the store, and the parents seemed to appreciate her. Louis was envious of her and used to incite the other children against her. The third child, Roy, was two years younger than the patient, and Louis had the impression that Roy was ashamed of him. Roy, a good student, was sociable, had nice friends, and made a better impression. Though Louis was older, he always felt inferior to Roy; he felt that Roy did not want to introduce him (such a shy, scared-looking, and shameful brother) to his friends.

The other three siblings did not play a very important role in the life of the patient. All of them, however, appeared to him to be better than he, to be preferred by the parents, and somehow to have a disparaging attitude toward him.

The atmosphere at home was very tense and insecure. Louis felt

that he could almost never obtain the approval of his parents. At the age of 14 he had to leave school because he was falsely accused of stealing a knife. He did not have the courage to defend himself in front of the teacher, and he was considered guilty. He could not face the class again and refused to go back to school. His parents did not insist that he go because they were discouraged by his poor academic achievements. Louis grew up with the idea that he was the black sheep of the family, that he was not only the most stupid member of the family, but very stupid—"not even intelligent enough to go to school," his father said. Louis tried to compensate for his scholastic failures by doing a lot of work in his parents' store, carrying heavy packages, doing everything he was asked to do, and so on. He never rebelled, but felt that no amount of work that he did was enough to redeem him in the estimation of his parents. He felt inferior, hardly tolerated, and tried to make himself as inconspicuous as possible in the family. He would never talk for fear of being ridiculed. Later he was afraid to associate with young men and especially with girls. He never had premarital sexual relations.

When Louis left his native city and came to live in New York, through friends he met a girl who became interested in him. He was

pleased by her attention, and they were married. This woman actually offered love to Louis, who accepted it enthusiastically and reciprocated. However, she always tried to mother and dominate him in a more or less subtle way. As has already been mentioned, when Louis came for treatment about ten years after his marriage, he had developed the idea that he was falling out of love with his wife. After a few sessions he admitted that he was afraid he was going to kill her. He was also afraid that his father was going to die.

During the first year of treatment, the family situation was explored. The parents, who in Louis's eyes were "very good and nice parents," were dethroned, and he eventually was able to trace back his excessive anxiety to his childhood. He would still insist, however, that his marriage was perfect and that his wife was a superior woman. During the second year of analysis, he came to the realization that he resented being dominated by his wife, whom he saw as a new parent. Domination was the price he had to pay for her love. When this situation was understood and he was able to express his resentment, he became more anxious for a while. Gradually, however, he became more assertive, less resentful, and lost the fear of killing her. He became able to accept her love and to reciprocate it in a genuine way.

Toward the end of the second year I felt that the treatment was successfully progressing toward a solution. And yet at the beginning of therapy, when I was not aware of many factors, I had been rather pessimistic, wondering why this patient, although very sick, was not even sicker. With an early atmosphere as threatening as his, with parents apparently so oblivious of their children's needs, with additional difficulties coming from the siblings, with such a desire to make himself inferior and inconspicuous, with this lack of self-esteem and despair of pleasing his parents, I felt that the patient could very easily have developed a schizophrenic disorder. The more I understood the dynamics of this case, however, the more I realized that this case could not develop into schizophrenia.

Several months after the beginning of treatment, the patient said that he was still suffering from a disturbing symptom that he had not mentioned to me as yet because he was too ashamed of it. He had peculiar food habits. There were many foods that he could not eat. These foods, which he excluded from his diet, did not follow any apparent pattern. He had never eaten some of these foods, not because he did not like them, but merely because he did not want to eat them. He was not even aware of any anxiety or fear associated with the act of

eating them. He assumed that they were very good, but he could not make himself eat them because he had never eaten them before. He could not explain the origin of this habit, which was very distressing and led to embarrassing situations when he was invited to dinner at his friends' homes and refused almost everything. His wife had to comply with his absurd likes and dislikes and could never prepare some of the foods that she liked. He later remembered that this peculiarity had existed since his childhood. No matter how severely he was punished for refusing to eat, he would not eat the "forbidden" foods. On this point he did not comply with his parents' wishes. His mother had to go to the trouble of preparing special foods for him every day so that he would not starve. During the course of treatment Louis gradually realized that his motivation was the following: he was forcing his mother, who was reluctant to do anything for him, to do this, at least to prepare special food for him. He forced her to do this extra work, which she was very reluctant to do. This may be interpreted as a manifestation of hostility and retaliation on his part. Certainly there was a big component of hostility in this attitude, but at the same time Louis got the feeling that he was not completely neglected, forgotten, or allowed to die of starvation; his mother was

doing something for him, too; she did love him; she gave him care and love as she did the others. This compulsive habit thus prevented him from developing that feeling of utter despair, of complete emotional isolation, that is harbored by the person who feels completely unloved and unlovable. That is why he had to cling to this habit so tenaciously; it was proof that he, too, got something, some love, from others. But he was not aware of the motivation of this habit, which therefore became a symptom. When he got married, he maintained the symptom, which served the same purpose. After the symptom had been interpreted to him and he had already accepted the fact that he was really loved by his wife, and when he had learned to assert himself even with her, the symptom disappeared.

One may conjecture that until the patient was psychologically prepared for an interpretation, this neurotic symptom had a useful purpose; without it the patient would have been much sicker. We may postulate that either intuitive choice or a combination of fortuitous circumstances made the patient select this protective neurotic defense. However, it would be erroneous to go so far as to think that without this protective neurotic symptom the patient would have developed schizophrenia when, after his marriage, his difficulties with

his wife reactivated the old anxiety. In fact, there are other indications in this case that schizophrenia was not likely to occur. But first, let us reconsider this symptom of not eating certain foods. The mother actually allowed this symptom to exist. It is more than doubtful that the patient would have died of starvation if he had not been given the special foods. Sooner or later he would have eaten the food that the others ate. Somehow Louis felt that his mother would respond to such a threat. On certain occasions his mother would respond, would do things only for him. In other words, he could "reach" his mother, although with neurotic mechanisms.

In addition, the general attitude of this patient is not the one found in the person who becomes schizophrenic. It is true that as a child he was withdrawn and tried to make himself as inconspicuous as possible; however, even when he separated himself from the others in a physical sense, he was very much involved emotionally in the interpersonal relationships of the family. He did not become apathetic or unemotional; the opposite is true. He was always emotionally involved. Furthermore, although he felt rejected, he tried, in spite of his skepticism, to gain the approval of his parents. He complied excessively, as when he helped them in the store. He did not comply in

a passive way, in order not to displease them, but in an active way, in order to regain the affection that he had allegedly lost on account of his poor scholastic achievements. Thus he developed a fundamentally compliant personality, not a schizoid or stormy one. Finally, he never doubted the values of his parents; at a conscious level he always felt that his parents were right and good, especially his father. A certain degree of identification with his father was possible.

Other factors played a role. Either because he considered his father's prediction as ineluctable, or because he chose to do so, Louis did not compete with the rest of the family and accepted himself as the only nonprofessional person in the family. Contrary to what happens in other less fortunate young people, he did not sustain repeated attacks to the self-image on account of this difference in status. Finally, the marriage with a woman who accepted him fully helped him considerably. When he temporarily felt dominated by his wife (who was not the ideal like Ingrid Bergman), his equilibrium was temporarily threatened. Treatment was able to restore the equilibrium.

Anthony

Anthony was a 32-year-old mathematician, single, Catholic, of asthenic constitution. He complained that while he was preparing for some examinations for his Ph.D. degree in mathematics, rather suddenly he felt unable to do his work. He felt that he could not cope with the situation any longer. The problems appeared insurmountable to him. He had not as yet finished his thesis, in spite of his recognized ability in mathematics. At his age, when he should have been married, his relationships with women had been very few. He had never had sexual relations. He had always found excuses for not going out with girls; he was too busy, he had no money, and so on. In social situations he felt very tense and awkward. He was afraid that people would see the gold filling in one of his teeth and therefore consider him maimed. He was also very much afraid to eat in front of people. He felt that while he was drinking a cup of coffee or a glass of water his hand would shake and people would notice and make fun of him. At times after eating he had attacks of nausea. A few times he had vomited after eating in the company of other people.

While working for over two years on his thesis, Anthony would always find difficulties that would delay the completion of the work. Finally he decided to change to another college and write another

thesis. He also had other symptoms. When he went to a high building, he was afraid of falling; if he was in the lobby of such a building, he was afraid that the building would fall on him. He felt very dissatisfied and lonely.

Anthony was the second of four children of poor Sicilian immigrants. The first child died when the patient was very young. The other two children were also boys. The father of the patient was an illiterate laborer. At home he spoke his native language, not having been able to learn English in spite of having lived in the United States for about forty years. He had never been very close to the patient or to the other children. He seemed to have shown some interest only in their scholastic achievements. He was not cruel, but apparently disinterested. He was never home, and in later years he had taken to drink and quite often came home intoxicated .

The mother was described as a very ignorant and very domineering woman. She was ignorant to such a point that she believed in the flatness of the earth. She had never praised the patient; she never seemed satisfied either with her husband or with Anthony. She seemed less antagonistic toward the other two children, and

Anthony always had felt as though he were the most disliked person in the family. His mother always told him what to do. To be with her at mealtimes was particularly unpleasant, because she would take that opportunity to make one criticism after another of him. His table manners were not good, he had not helped her enough with the housework, he had done so many things wrong. His mother was also very strict about the children's observance of all the rites of the Catholic church; she made sure that no one transgressed, and she sent the children to a Catholic school, directed by nuns. Guilt and sin were concepts always present in the teachings of that school. The atmosphere at home and in school was intensely colored by this religious feeling; life was just a preparation for death; the only purpose of living was the salvation of the soul. The patient remembered his very intense feelings and ideas about religion since childhood. He recalled an extraordinary experience that he had at the age of 12, when he looked up at the sky and felt that a voice was reaching him, saying, "You must become a priest." He interpreted this voice as a message from God. He never had a similar experience either before or after that one. He staggered; he was perplexed and astonished, but decided not to tell his mother or anybody else what

had happened. He wanted to enter a Catholic seminary, but his parents discouraged him. After that experience he worried for months. He was afraid to look up at the sky for fear of receiving messages again. At the time this event occurred, he felt that the future was dissolving because he did not want to become a priest, but that he had to obey God. He felt sure that God wanted him to become a priest; however, he felt that as long as he did not get married, he could always postpone becoming a priest, and would eventually become one. When he was an adolescent, he felt that one of the reasons for not going out with girls was the knowledge that he had the mission from God to become a priest, in spite of his desire not to do so. Even at the beginning of treatment, when the patient was 32, doubts about this religious experience remained. Even then Anthony felt that it was a genuine religious experience. "If such things exist, if people receive messages from God, then this was one of those instances," he would say.

Anthony also had obsessions that were religious in content. Before Holy Communion one is not supposed to eat. He was afraid that some nasal drip or swallowing of his saliva would constitute eating and therefore make him unsuitable for Holy Communion. He was also afraid of committing sins in the interval between confession and Holy

Communion, when one is supposed to remain pure. These sins were sinful thoughts about his mother, which consisted of believing that his mother wanted to get rid of him and put poison in his food. Often he did not want to eat his meals, fearing that his mother had poisoned them. He felt ashamed of these ideas; a good son should not have such thoughts about a loving mother. Twice he revealed these thoughts to the priest during confession. The priest agreed that those were sinful thoughts.

The patient remembered some fantasies that recurred during his late childhood and adolescence. He was the slave of a cruel queen. This queen would make him do degrading things, such as washing her feet, kneeling in front of her, and doing many humble forms of work. He would always obey, gladly, to please the queen at any cost.

The patient remembered some sex talk among the boys in grammar school, but during adolescence he never spoke about sexual matters. Attainment of sexual gratification was considered by him absolutely beyond the realm of possibility and very sinful. He had started to masturbate at the age of 28, as far as he remembered .

At school the patient had always been a very good student. During World War II, he had been deferred from service because of the position he had as a mathematician. After the war he resumed his studies toward a Ph.D.

The personality of this patient has to be described in more detail. He had always cultivated very few friends and had spent most of his time by himself, avoiding social contacts as much as possible. At the same time he felt lonely and ashamed of being alone. He had always found pride and comfort in intellectual achievement. At the beginning of treatment he felt quite lost when, during the session, he was requested to say just what came to his mind. He wanted to follow an outline, or at least be given a topic. Often he would ask for a book where he could learn what to talk about during the session. The inability to prepare in advance for the therapeutic hour was very disturbing to him. When he was asked to describe a certain feeling that he was experiencing, he would beg the therapist to give him a list of possible feelings so that he could recognize the one that he was experiencing. He had to anticipate the direction in which the therapist or the treatment was aiming, and as a result he had difficulty in making contact with the present feeling. In other words, he felt

completely at a loss when he had to do something spontaneously. He had acquired a certain degree of security by doing everything as it should be done, according to a certain routine. Everything had to be planned or known in advance. He would often point out the superiority of the mathematical method as compared with the therapeutic. This psychological attitude also had some repercussion on his mathematical views. For instance, he did not accept quantum theories because they leave room for unpredictability and uncertainty. In the beginning he was disappointed that the therapist, after knowing his symptoms, had not been able to classify him properly, and thereafter follow the most economic and efficient methods to elicit the other symptoms and the causes. He felt that the therapist should be able to classify him in a certain category and by doing so know everything that was to be found in him.

Although many other interesting facts concerning this patient have to be omitted, we are now in a position to understand several processes that have occurred in his life. Again we have an unhappy childhood. The father, with his detachment, the mother, with her hostility, were both destructive. One wonders whether or not the events described by the patient, such as hearing the voice of God and

being afraid of being poisoned by his mother, were full-fledged schizophrenic symptoms. Feeling so rejected and hopeless about obtaining his mother's approval, the patient needed to believe that God had accepted him and wanted him to be a priest. Maybe God in heaven was a substitute for his emotionally distant father, from whom he wanted, but could not get, a message of love and encouragement. God would accept him if he became a priest and stayed away from women, that is, from his mother. In an environment permeated by religion, such as the one in which Anthony was raised, the idea of having a mission from God is not necessarily a delusion. It must be admitted, however, that the anxiety and distress of the patient must have been very intense if they caused him to develop this nonrealistic belief. Whether the experience was a real hallucinatory one or not cannot be fully ascertained. An uncertain belief in the reality of this experience remained until the patient was at a fairly advanced stage of treatment.

As for the fear of being poisoned, we have to remember that it occurred only at mealtimes. During these times Anthony's mother used to shower her nasty criticisms on him. To be near her during lunch or supper was an ordeal. In a metaphorical sense she poisoned

his food. In the symptoms, this metaphor was changed into a concrete act; mother might actually have poisoned his food. Even in this case, however, the patient was doubtful; most of the time he felt that it was not true and felt guilty for having such a belief. Later in his life, when the symptomatology changed and followed a more psychoneurotic picture, he felt extremely anxious during meals, especially if he ate in company. He attributed the anxiety to his bad table manners and fear of criticism. Again, symbolically, the people who watched him were mother-substitutes, who saw how worthless he was. From the time of adolescence, many of these ideas disappeared; the patient improved, and in certain areas, like the scholastic, he made a good adjustment. One wonders why this situation, which in early life seemed oriented toward a schizophrenic breakdown, took a turn for the better and changed into a less serious one.

If we reexamine the childhood, we see that already there were elements more typical of the psychoneurotic than of the schizophrenic pattern. The patient never lost the desire to please his parents. The recurrent fantasy about the cruel queen indicates his desire to placate his cruel mother at any cost. In other words, he had not become hopeless about obtaining her approval. He was concerned about

obtaining this approval, no matter what it entailed, and therefore there was no emotional detachment. The fantasy about receiving the order from God to become a priest is also something of the same nature. In the fantasy of the queen he is the slave who has to do horrible things to please her; in the fantasy of God he has to become a priest and keep away from women. It is true that he has to submit reluctantly, but at the same time he has been chosen by the queen as the servant, and by God as his minister. In a certain way he has been accepted and approved. We see indications that he will develop not a completely detached personality, but elements of a dependent, compliant character that will play an important role in his makeup.

The desire to gain the approval that his siblings had already obtained gave him the stimulus to go further in life than they did, and to become the most educated, and the most advanced, professionally, in his family. He chose the field of mathematics, which requires very little emotional involvement, and in which every step necessarily follows the previous one and can be predicted. He also developed schizoid traits, characterized chiefly by removal of spontaneity. Any spontaneous act might incur the disapproval of his incorporated mother. If he did what he was "supposed to do," he would remove

anxiety. He had removed sex entirely from his life; he had no respect for his emotions, which he tried to repress all the time. At the age of 32, he wanted to look for a wife because at that age a man "should" marry. This combination of a compliant and schizoid personality protected the patient from the anxiety that could have engendered a schizophrenic psychosis. By removing spontaneity, he became withdrawn and apathetic; but by doing what he should do all the time he manifested his willingness to comply with the authority in his family and in his society. This mixture of very pronounced compliant and schizoid personalities protected the patient from psychosis. However, it impoverished immensely his life. Were he to relinquish these defenses, he might still become a victim of psychosis.

Arthur

Arthur was a 25-year-old white man who sought psychiatric help because of an apparent lack of emotions, obsessive ideas, compulsions, occasional stuttering, and "peculiar thought disorders." The "peculiar thought disorders" were the symptoms that distressed him most. He did not know how to explain them and attributed them to a serious mental disease. He noticed that often normal thinking was impossible

for him because it was replaced by a strange form of thinking that he recognized as abnormal. This disorder occurred not only while he was thinking, but in talking and reading. Here are some examples taken verbatim:

> "I see in the paper 'Camera Fotoshop' and I read 'Campo Formio,' which is the name of a peace treaty. I see 'Triumph' and I read 'Truman.' While walking on the street I saw a girl with a button on her blouse on which a word was written beginning with a large *F.* I immediately read it as 'Frustration' but on coming closer I saw it was 'Fieldston,' the name of a school. When I meet people who have a certain appearance and manner, a name will often flash into my mind and I will think of this name each time I see the person subsequently. The name 'Higinio' flashes into my mind whenever I see a certain fellow whom I recently met. He is short, and the black hair on his head sticks up like a porcupine's. All this seems to me to be so much more appropriately expressed by the name 'Higinio' than by his actual name. . . .
>
> "Once I saw a letter on my uncle's desk in which were the words 'Lyon's velvet.' I immediately thought that the letter must have come from England. The fact that the letterhead and the stamp showed it to have been sent by an American firm did not cause the feeling to vanish; the facts, on the contrary, seemed inappropriate because they contradicted what I somehow felt should be the truth. Now

> the word ‘Lyon’s’ rather suggests England to me; it seems an English rather than an American name. There is a chain of restaurants in London called ‘Lyon’s restaurants.’ Moreover, I have always associated the manufacture of textiles, such as cotton and velvet goods, with England. So I had a definite feeling that the letter must have come from England and been written by an English firm. . . .
>
> “When I lie in bed at night or early in the morning, long strings of words, many of which are meaningless, will pour into my mind. These appear to have a meaning sometimes. Other times completely meaningless sentences come up; for instance, ‘Spain for a half-inch sword.’ ”

At the beginning of treatment, the patient described other experiences that had a disturbing effect on him. He generally took a bus to come to my office. At times when he got off at the stop nearest my office, he had the impression that the other people who got off at the same time were also coming to see me. He recognized the unreality of such an idea and did not *believe* that the other people came to my office, but he had a *momentary feeling* that they were doing that. Occasionally, when he was riding in buses or subways, if he saw people talking, he had the feeling that they were talking about him. He realized almost immediately that it could not be so, and actually he did not think that they were talking about him, but for a fraction of a

second he had that feeling.

The patient also complained of emotional indifference and apathy. He used to say repeatedly that he had lost all his emotions. He could not become involved in anything. When he had to do something, he was going through the motions of what he had to do without any emotional participation. Life appeared colorless to him. He could not force himself to do anything; he just wanted to be left alone. On account of this thought disorder and apathy, he could not concentrate on his studies. He had intended to get his M.A. in mathematics, but had to give up the idea. He would not go out with girls because it was too much of an effort to ask for a date. Never in his life had he had sexual relations. He would go into parks and become sexually aroused at the sight of girls lying on the grass.

Arthur was born in England. There was no history of mental or nervous disorders in his family. The father had died about ten years before of cancer. The patient did not love him; as a matter of fact, he had experienced relief when he died. Arthur remembered attempts he had made during his childhood to get close to his father. His father used to take him to restaurants or to movies occasionally and would

tell him stories. However, whenever the patient started to feel a little warmer toward him, his feelings were generally changed by his father's subsequent nagging attitude. Arthur felt that it was better not to allow himself to get close to him and never confided in him.

During adolescence, Arthur's father appeared to him as a tyrant who was always after him, like a policeman, to investigate whether he had masturbated or not. If the patient had a pimple on his face, or was pale, the father would say that these were signs of masturbation and that terrible things would happen to him. Because the patient had actually masturbated, he felt guilty; he felt that his father could read "through him" and was afraid that he would develop serious diseases. He was also afraid of actual punishment from his father.

The patient hardly remembered how his mother appeared to him during his early childhood; he rarely saw her, because he was almost always cared for by a governess. He did not remember having been caressed or kissed by his mother, or having done anything with her in his early years. For several years he was taken care of by a governess who later developed the paranoid type of schizophrenia. Later on, when the parents came to the United States, they could not afford

maids, and Arthur had more contact with his mother. At the same time, however, he had the impression that his mother was much more concerned with his sister, who is his only sibling and four years younger than he. Arthur considered his mother a very weak person. She was not tyrannical, like his father; however, when the latter bitterly criticized and punished Arthur, she never came to his defense, but was always on his father's side. After the father's death, when Arthur was 15, his mother tried to get close to him, but it was too late. Somehow the patient did not trust her.

Arthur remembered both parents, from his early childhood on, with a sense of annoyance or disgust. Being near them was unpleasant. He felt that they were ugly; he even had the impression than an awful odor emanated from their bodies. He had to obey all the time, to avoid his father's punishment; he never put up a fight. He tried rather to detach himself from them. To use his own words, he felt that "Those adults were intolerable naggers who never understood you. Why bother to defend yourself?" He did not play much with children of his own age and stayed by himself most of the time. He had vivid fantasies that persisted throughout adolescence and kept him busy when he was alone. In his mind he had constructed an imaginary world made

up of countries of different periods in the recent or remote past, which he had learned about in history.

Ever since childhood he had also been disturbed by obsessive thoughts. The following is a verbatim description of some of them:

> "I was very impressed by religion from an early age, and my obsessions consisted of horrible ideas about Jesus Christ, that he was unclean, or that I should urinate or excrete upon him or upon his mother. I also had similar thoughts about God, and often I would fantasy that God or Jesus or his mother would perform similar defiling actions upon one another. I also remember compulsions to fill all my pockets and to perform all kinds of actions an even number of times. For instance, if I spilled some soup by accident and was reprimanded by my parents, I would nevertheless feel obliged to repeat the act in order to make an even number."

From the time that he was 16, Arthur fell in love periodically with girls. These loves were never manifested. For one reason or another these girls were unattainable, or he imagined that they were unattainable (they lived in different cities, were of a different religion, and so on). These unmanifested loves were so intense that they caused relatively important changes in his life. For instance, while he was attending college, he took courses that were unnecessary in his

curriculum, wasting time and energy, only because the girl he loved was taking them. He had always been an excellent student, but in the last few years there had been a decline in his scholastic achievements, and finally he had had to interrupt his studies.

Many other things could be said about this interesting patient, especially in relation to treatment. However, we have to limit ourselves to the consideration of what is relevant to the subject of this chapter. Here again is an example of an unhappy childhood. The early uncanny experiences had been very well repressed by the patient, who had very little recollection of the role played by his parents during his early childhood. He did not succeed, however, in repressing entirely the bad images of his parents, for whom he always had hostile feelings. He remembered his past life from the age of 5 or 6. Reality was so unpleasant that the child had to isolate himself emotionally. He did not dare to put up a fight; it was useless to fight the adults; the best thing to do was to disregard them. He justified his detachment perhaps by visualizing them even worse than they were. While he was detaching himself, he was also preserving the individuality that he had been able to acquire. At the same time these difficulties with the significant adults in his early life did not help him to become an integral part of

the social world in which he had to live.

He was living in his own world, a world made up of fantasies. As will be further discussed in Part Three, this detachment gave momentum to autistic tendencies, which were retained by the patient up to the time he came for treatment. Even during the second year of treatment, autistic tendencies, represented mostly by thought disorders, tended to come back when he was faced with a situation that provoked strong anxiety.

By detaching himself from his parents, Arthur succeeded in finding a more or less stable equilibrium. He became aloof, reserved, and pseudocompliant. After puberty, however, the situation changed. His father, with his own obsessive thoughts about sex, did not allow him to be aloof and detached. This attitude increased the patient's hostility toward the father and stimulated further detachment. After the death of his father, Arthur was confronted with new problems: guilt about having wished his death, inability to gratify his sexual urges, and feelings of inadequacy when he attempted to establish social relationships. His mother could not help him. Although she was finally willing to get closer to him, he was somehow afraid of her

"smothering" attitude and he had to reject her.

The situation deteriorated to such a point that the picture presented by the patient when he came for treatment consisted not of just a strong or very rigid schizoid personality. Especially in anxiety-arousing situations many autistic phenomena were occurring. Some of them did not seem of too serious significance. He read "frustration" instead of "Fieldston" on the button pinned on the girl's blouse. Girls represented frustrations to him, or his frustrated attempts to love. Everything that was associated with England, where he spent his childhood, was charged with great emotional tone for him. Thus, when he read Lyon on a letter found on his uncle's desk, he thought that the letter came from England. Some other symptoms gave almost a schizophrenic appearance to his condition. For instance, he had pseudoideas of reference, tendencies toward neologisms, and psuedo-word-salad phenomena. I use the prefix *pseudo* here because these experiences were not accepted by the patient as reality, but were immediately recognized as abnormal manifestations. It was only the preservation of the ability to test and disprove their reality, however, that distinguished them from full-fledged schizophrenic symptoms. The formal structure of the symptoms was the same as in cases of

schizophrenia. The patient also presented some symptoms of depersonalization. He did not experience emotions; at the same time, he was aware of his emotional bluntness and was afraid of developing schizophrenia, the symptoms of which he had read in psychiatric books, which he had studied avidly.

Indeed, Arthur was very close to schizophrenia, and it is a fair guess that if he had not come for treatment at this point, the psychosis would have developed. Many psychiatrists, I am sure, would have diagnosed this case as schizophrenia. The typical background for a schizophrenic psychosis was present: experience of being rejected by both parents; development of a strong schizoid personality with great propensity for autistic phenomena; inability of the patient to defend himself from the increasing difficulties after puberty, in spite of the rigidity of the schizoid personality. There were also, however, some favorable signs, which may explain why the patient did not develop a psychosis. First, his father's attitude toward him was ambivalent and he did make some effort to reach him. The patient, however, did not trust these efforts and preferred detachment. Later he felt that if only he could abstain from masturbation or from sexual desires, he could obtain acceptance from his father. The sexual urges were very strong,

however, and he had a feeling of hopelessness about being able to suppress them. A second relatively favorable sign was the fact that from early childhood this patient protected himself, not with detachment exclusively, but also with compulsive symptoms. Although some of them could have had the purpose of retaliating against the parents (spilling the soup twice), they also protected him from anxiety.

The treatment of this patient has been long and laborious. He was in therapy for eight years, but he made steady progress. There was an affective reintegration, and he soon became aware of his anxiety, especially in social contacts with the opposite sex. The autistic phenomena entirely disappeared. He was able to resume his studies and to secure an important position as a mathematician.

The writer had the unusual opportunity of having followed these three patients for more than twenty years. In fact, he maintained some contact with them after termination of treatment. Was schizophrenia really averted by them during this long part of life?

Let us start with Louis, the first patient reported in this chapter. Approximately fifteen years after termination of treatment, Louis called me and asked for a consultation. His mother was dying of a

serious disease, and he felt anxious, guilty, almost as if he were responsible for her condition. His old anxiety was reactivated. Apparently the hostility he once had for her had not been completely solved. A few sessions were able to restore the state of health. There were no signs of schizophrenia. Louis has been able to work steadily all these twenty years and to live harmoniously with his wife.

As to Arthur, he got married shortly after termination of treatment. He has been able to retain important professional positions, but continues to have hypochondriacal preoccupations. No thought disorder of any kind has reappeared.

In comparing the cases of Louis and Arthur, it seems obvious that whereas in the case of Louis there were strong indications that he would never develop a psychosis, in the case of Arthur the psychosis was very near. Some would think that perhaps it was already active in a slow, insidious way. It seems likely that a full-fledged psychosis was averted by a narrow margin through therapeutic intervention.

The case of Anthony is more complicated. He stopped regular treatment shortly afterward, but for a few years maintained irregular

and insufficient contacts with me. Professionally he did well. He was able to obtain his Ph.D., secured a position as a teacher of mathematics in a college, did important research, and wrote papers that were promptly accepted for publication. Personal life has not been equally successful. While he was coming regularly for treatment, he was able to improve his social contacts with women. He was never able to establish a deep or very meaningful relationship. When he stopped treatment against advice, his social contacts decreased, and there was a marked accentuation of his schizoid traits. He stopped entirely going out with girls. He wrote some papers that were rejected. Because he was sustaining his self-esteem on his academic achievements, this was a serious defeat. He followed in his father's footsteps and started to drink. In a few years he became an alcoholic. Nevertheless he was able to teach and retain his position. A few years later when Anthony called me for consultation, I found Anthony in a state of delirium tremens with visual and tactile hallucinations, including the typical ones of small animals. The patient quickly recovered from this episode and seemed to be improved as far as his alcoholic habits were concerned. However, it is difficult to predict the ultimate prognosis as far as his addiction is concerned. He moved to another city, where his family

lived. He continued to teach mathematics in a college.

The case of Anthony is interesting from a nosological point of view because he experienced early in life what were questionable psychotic symptoms. Do alcoholic psychoses tend to occur in people who are close to schizophrenia or potentially (or latently) schizophrenics? We know that some authors have postulated a close relation between schizophrenia and alcoholic hallucinosis. Anthony, however, presented a delirium tremens syndrome.

In spite of all these complications and psychiatric difficulties we may say that Anthony, too, averted schizophrenia or at least typical schizophrenia. He remained a great psychiatric challenge.

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