INTERPRETATION OF SCHIZOPHRENIA

Epidemiology of Schizophrenia

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I
Introductory Remarks

Epidemiology is a science and methodology whose object is to determine whether there is an association between a rate of illness and the changing strength of an environmental factor. For instance, if the population that smokes has a higher rate of lung cancer, then there is a positive association between lung cancer and smoking. Similarly we know that the incidence of schizophrenia is 0.85 percent in the general population. If we find that populations having a special characteristic have an increased incidence of schizophrenia, then we find a positive association. This positive association does not necessarily indicate that the characteristic in question is the cause of schizophrenia, but that it may affect in a positive way the etiology of schizophrenia. Conversely, if we find that the incidence of schizophrenia is decreased in populations having a certain characteristic, we cannot conclude that that characteristic is a cure or preventive factor of schizophrenia but that it may be part of a set of

factors that are used by the individual to prevent schizophrenia. The characteristics that are studied in relation to the incidence of schizophrenia may be biological, psychological, sociological, or difficult to categorize. For instance, let us take as an example the studies relating birth order—that is, the position of an individual among his siblings—and the rate of schizophrenia. Birth order is connected with family size and with age of the parents because first born children tend to have younger parents than those born last. The sex and spacing of the siblings give a special meaning to a given position. Moreover, being the first, middle, last, or only child, or the only boy or girl, may give special meaning to the family constellation.

Needless to say, the epidemiology of schizophrenia is very much hampered by the fact that there are marked variations in the ways schizophrenic patients come to the attention of physicians, in the ways the diagnosis of schizophrenia is made, in the ways patients are hospitalized, kept in hospitals, and so forth. For instance, it is well known that American psychiatrists make the diagnosis of schizophrenia more frequently than their European colleagues, many of whom limit this diagnosis to patients with classic Kraepelinian symptomatology. Another important task is to establish the difference

between the *prevalence rate* and the *incidence rate* of the condition.

The incidence rate is the number of new cases of a particular illness per 100,000 population occurring during the period of a year. The calculations of the incidence rate are susceptible to quite large errors. We have already alluded to the fact that in some psychiatric hospitals or schools many patients difficult to categorize are diagnosed as schizophrenics. The opposite is true in other hospitals and schools. In many studies the incidence has been calculated only on the basis of first admissions to psychiatric hospitals. However, we know that there is a *surplus* incidence, consisting of schizophrenic patients who are never going to be hospitalized.

The prevalence rate is the total number of cases per 100,000 population (not just the new ones) suffering from the disease during the period of a year. In the case of schizophrenia, calculations of prevalence rates are made difficult by different rates of discharge, various degrees of tolerance of the general population, and by different opinions among psychiatrists on who is to be called "schizophrenic." Some psychiatrists consider a person a schizophrenic for his whole life if he has had a schizophrenic episode once in his

lifetime. Other psychiatrists, lately in an increasing number, feel that a patient can recover from schizophrenia just as he can recover from pnuemonia; in their opinion a recovered schizophrenic should no longer be called a schizophrenic. This point of view leads to a much lower prevalence rate. Thus prevalence rates are very unreliable and vary from 170 to 950 per 100,000 population (Yolles and Kramer, 1969).

II
Some Vital Statistics

Lemkau and Crocetti (1957) estimate a minimum incidence rate for schizophrenia of 50 per 100,000 population. Yolles and Kramer (1969) report an adjusted rate of 116.8 per 100,000 for schizophrenic reactions. They also report staggering figures that they have obtained from the Annual Statistical Reports issued by the U.S. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health. Schizophrenic patients, residents in state and county mental hospitals and Veterans Administration neuropsychiatric hospitals, numbered 289,055 at the end of 1964 and constituted half of the population of these hospitals. Schizophrenics

made up 32 percent of new admissions to these hospitals, 20 percent of new admissions to private hospitals, and 15 percent of new admissions to 2,000 outpatient psychiatric clinics in the United States.

Yolles and Kramer report that the rate of first admissions to state and county mental hospitals was 15.3 per 100,000 in 1964. There was a great variation among the states, from a high of 31.1 in one state to a low of 3.7 in another.

These data do not vary very much from those that I reported for the year 1949 (Arieti, 1959). In 1949 the median first admission rate to state hospitals was 15.0, with the highest rates found in the District of Columbia (39.8) and New York (30.6) and the lowest in Kansas (4.7) and Wyoming (5.9). Yolles and Kramer report that of the total first admissions during the year 1964, 53 percent were patients between the age of 25 and 44; 20 percent were 45 or older. Patients under 15 years of age have doubled between 1950 and 1964, and the trend continues. On the other hand, from 1955 to 1964 there has been an annual decline in the resident patient population in state and county mental hospitals in the United States of 13 percent.

The marital status of the patient seems to be positively correlated with the rate of admission to state hospitals. It seems that bachelorhood, separation, divorce, and widowhood are poor risk in comparison to marriage. Yolles and Kramer report that the single male has a rate of admission to psychiatric hospitals that is six times greater than the married male; the divorced and separated male, eight times greater; the widowed, five times greater; the rate for the single female is three times greater than for the married female; the divorced and separated, five times greater; the widowed, three times greater.

The usual explanation given for the higher rate of admission in single persons is that people with psychological instability may be less fit to marry and more disposed to schizophrenia than the average person. Farina, Garmezy, and Barry (1963) added that in an industrialized society the male takes a more active role in courtship and selection. Men thus need to be more adequate than women in order to attain marital status. Consequently married men should show a lower rate of schizophrenia. As a matter of fact, statistics gathered by Farina and co-workers show that the rate of schizophrenic married women exceeds the rate for married men. There was actually no sex difference among patients who remained married, but the rate was

much higher for women among the divorced and separated. The authors concluded that whereas the unstable man tends to remain single, the unstable woman tends to get married and get divorced.

Several authors (Grosz and Miller, 1958; Smith and McIntyre, 1963; Burton and Bird, 1963) have studied the association between birth order and schizophrenia but obtained negative results. Schooler (1961) found a positive relation in the rate of the disorder in siblings born last in comparison to those born first. He suggested the hypothesis that the mother's "increasing age or large numbers of previous children may affect the intrauterine environment in such a way as to leave the child with a physiologic predisposition to the disease." Contrary findings were obtained in India by Rao (1964), who determined a greater rate of schizophrenics among siblings born first or second.

Erlenmeyer-Kimling, Van Den Bosch, and Denham (1969) have reviewed the data of several authors from various cultures; they also studied data from 1,348 subjects and reached the conclusion that there is no association between schizophrenia and birth order.

Hare and Price (1968) studied the season of birth of schizophrenics and found an excess of winter births in schizophrenic patients compared with neurotic patients. To explain their findings, they advanced the following hypotheses, which to me seem indeed hard to accept: (1) protein deficiency in the mother's diet during the hot summer months of her early pregnancy or maternal ascorbic acid deficiency in later pregnancy or infectious diseases to which a winter-born child is more exposed would determine constitutional damage that in its turn would favor the penetration of a major schizophrenic gene; (2) unstable parents are less able to time their conceptions in order to avoid the less desirable winter birth. The children will have an increased liability to mental illness, not directly from their winter birth, but genetically (or culturally) from their unstable parents.

III
Schizophrenia Among Immigrants and Minority Groups

Many authors have found a higher rate of schizophrenia among immigrants than native populations.

Malzberg (1959a, *b,* 1962) has made many accurate studies that prove beyond doubt that schizophrenia is much higher among

immigrants from foreign countries and also higher in migrants from one part of the United States to another. Locke, Kramer, and Pasamanick (1960) obtained similar findings. Eitinger (1959) found psychoses to be ten times more frequent among refugees from different countries than among native Norwegians. In his work he stressed the fact that the immigrants were *refugees.*

Halevi (1963) reported that in Israel the immigrants from Europe have a lower incidence of schizophrenia than the native Jewish population. Astrup and Odegaard (1961) in Norway found a lower incidence in immigrants, except for those who went to reside in the capital, Oslo. In Australian Cade and Krupinski (1962) and Schachter (1962) found psychoses more frequently among non-British immigrants than among British, possibly because the latter had less difficulty in acculturating.

The cited works are representative of a large number of studies, the majority of which demonstrate that immigration to a new country increases the risk of schizophrenia. There are two possible explanations for this increase in risk: (1) only those who are more predisposed to schizophrenia emigrate to a foreign country; (2)

immigration *per se* predisposes to schizophrenia.

The first explanation seems to intimate that people who have a latent, preexisting predisposition to the psychosis emigrate more easily; that is, those more inclined to emigrate to a foreign country are the discontented, among whom there may be a higher percentage of gifted people who do not accept things as they are, as well as a higher percentage of potential psychotics. It seems more probable, however, that immigration *per se* is an important predisposing factor. The change from one culture to another, from one way of living to a different one, requires a strenuous effort. Thousands of readjustments have to be made, which may exhaust the psychic reserves of the individual and may allow deep-seated conflicts to break through. In the state of California the immigration consists mainly of people coming from other areas of the United States. The cultural readjustment thus is less marked, and this factor may explain why the rate of schizophrenia there is lower than in New York, where immigrants come predominantly from foreign countries.

However, it is impossible to isolate immigration from other, often concomitant, factors. Immigrants generally belong to special ethnic

groups, constitute cultural or religious minorities, have a lower economic status, and in some cases are the victims of prejudice, discrimination, and exploitation. It is difficult to evaluate each of these variables. In Israel, where the number of immigrants is larger than the number of natives, schizophrenia is reputed to be more frequent among the natives, who constitute a minority.

Malzberg (1959b) found that the rate (per 100,000) for schizophrenia among Jews was lower (35.5) than the rate for Protestants (41.7) and Catholics (41.2). Malzberg (1956, 1959a, *b)* reported that the incidence of schizophrenia among blacks and Puerto Ricans was twice as high as that of the general population. Pasamanick (1962, 1964) believes that the different rates of schizophrenia among the various ethnic groups (especially among blacks) have much more to do with economics than with ethnicity.

Kramer (quoted in Yolles and Kramer, 1969) reported that in a study carried out by the National Institute of Mental Health in 1960 in thirteen states, the first admission rate for schizophrenia among blacks was 2.6 times the rate among whites.

Some authors, like Pasamanick, rightly take into consideration the importance of economic factors, but practically no author takes into sufficient consideration the factors of discrimination and prejudice in their total effect.

Sanua (1962) applies some of my ideas (Arieti, 1955) to his findings about the incidence of paranoid and catatonic schizophrenia in Jewish and Protestant patients. Sanua found more parental rejection and "consequently" more paranoid schizophrenia among Protestants than among Jews. Conversely he found more overprotection and "consequently" more catatonic schizophrenia among Jews than among Protestants.

IV
Ecology and Social Class

A few decades ago Faris and Dunham (1939) published a book on the ecology of mental disorders that for a long time was considered a classic. These authors studied the distribution of schizophrenia in Chicago and Providence, Rhode Island, and found that the incidence varied in the different areas of these cities. The findings of Faris and Dunham have been confirmed by several other authors (Green, 1939;

Queen, 1940; Schroeder, 1942), who have repeated this research in other American cities. The areas with a high incidence of schizophrenia are areas of highly mobile population. They are the centers of big cities, which also have a high incidence of delinquency, crime, prostitution, and drug addiction. In other words, they are in a state of social disorganization or anomie. In these areas in which low economic classes live, the role of the family and its members is very unstable. Psychological isolation, faulty socialization, and deprivation of many sorts are common. Faris, who was the senior author of the original work with Dunham, repeated in a subsequent book (1955) that social isolation and disintegration, in the high degree in which they occur in big cities, are important determinants of mental illness.

The size of the city is also of pathogenic significance. Landis and Page (1938) found that the rate of schizophrenia increases proportionately with the size of the city. At the time of their investigation, the rate of first admissions in New York City was 28.7 patients per 100,000 population, whereas progressively smaller communities had smaller rates.

For a long time a prevailing theory postulated that schizophrenia

itself was responsible for a “downward drift” or a downward social mobility among patients. Lystad (1957), for instance, studied social mobility of schizophrenic patients in New Orleans and concluded that the patients showed “less upward status mobility than matched, non-mentally ill persons.” Hollingshead and Redlich’s (1958) research in New Haven seems to disprove that hypothesis. According to these authors the families of schizophrenics are not more prone to move downwardly than the normal population. As a matter of fact, the authors were impressed with upward mobility in some instances. The authors found that the incidence of schizophrenic patients in the lowest class was eleven times greater than in the highest class.

Goldberg and Morrison (1963) criticized the works of Hollingshead and Redlich. They indicated the technical reasons why in New Haven studies the poorer fathers would be overrepresented and therefore wrong conclusions would be reached. Their study reconfirmed the old hypothesis of an association between high rates of schizophrenia and low occupational status.

Studies of social mobility present tremendous difficulties because they have to be matched by studies of comparable groups of

nonschizophrenics. The point of origin, in terms of social status, is important. Thus if the person with a low position becomes schizophrenic, probably his mobility is less affected than that of a patient who had a prominent position.

V
Urbanism and Industrial Society

In a paper published some years ago (Arieti, 1959), I studied the rate of schizophrenic patients admitted for the first time to psychiatric hospitals in the United States and in Italy. The rates for Italy, provided by Professor Francesco Bonfiglio, who was then director of the Statistical Department of Mental Diseases in Italy, were based on the annual average of the triennium 1947-1949. The rates for the United States were calculated on the estimated 1949 population, from data obtained from *Patients in Mental Institutions, 1949,* published by the National Institute of Mental Health. Figure 50 and Table 1 show that in most of the northern industrial areas of Italy the rate of schizophrenic patients admitted for the first time to psychiatric hospitals was approximately 10 to 12 for 100,000 inhabitants. If we take regions in the south of Italy, like Puglie, Calabria, and Sicily, the admission rate

was from 3.3 to 6 per 100,000. In Calabria, which is a very rural, technically backward region in the south, the incidence was one-fourth the incidence in Emilia (Bonfiglio, 1952).

These striking differences can be explained in the ways mentioned in the second section of this chapter. It may be that in the Italian regions where the admission rate of schizophrenics was low, two factors operated: (1) not all patients were admitted to psychiatric hospitals, but many were kept among the general population; (2) the proper diagnosis was not made; therefore, many patients were not recognized as mentally ill, or if they were recognized as such, the wrong diagnosis was made.

According to the first hypothesis, in certain regions people would resist hospitalizing patients for fear of stigmatizing the whole family.[1] I tend to believe that a different attitude toward hospitalization cannot entirely explain the differences in the admission rate. In certain Italian rural areas relatives are tolerant toward mental defectives and especially toward senile patients, for whom they retain respect. As far as schizophrenics are concerned, however, the attitude toward their hospitalization is not much different from one geographical area to

another.

Undoubtedly there are many schizophrenics who are not hospitalized. But that is true for every geographical area and every country. Many of those nonhospitalized patients represent latent or nonobvious cases, persons who are not recognized as sick or who are easily tolerated. There is also a certain number of more overtly psychotic patients who, as a result of particular circumstances (for instance, the fact that they live alone), escape hospitalization. Probably they are approximately the same percentage of the total number of schizophrenics in every country or in every region.

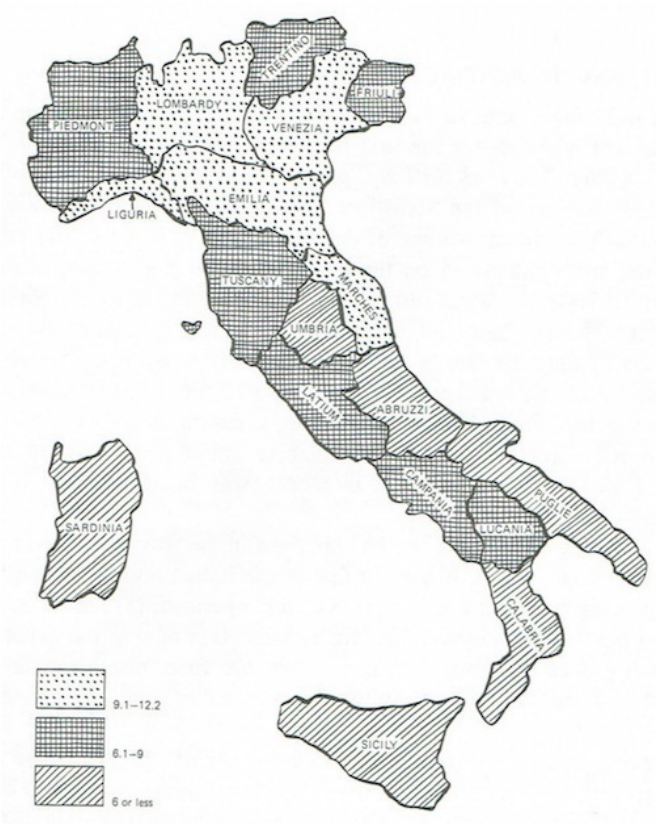

Figure 50

TABLE 1

First admissions of schizophrenic patients to public psychiatric hospitals in Italy. The rate is per 100,000 inhabitants and is based on the annual average of the triennium 1947-1949.

Abruzzi	5.8	Marches	9.7

Calabria	3.3	Piedmont	7.8
Campania and Lucania	7.9	Puglie	4.9
Emilia	12.2	Sardinia	6.0
Friuli	6.5	Sicily	6.0
Latium	7.2	Trentino	8.0
Liguria	10.9	Tuscany	7.6
Lombardy	11.8	Umbria	3.7
		Venezia	9.4
	Italy	8.2	

The second explanation of the difference in rate of admission is

that the wrong diagnosis is made, that is, that in certain regions of Italy some patients are recognized as psychotics, but are admitted under a different diagnosis—for example, they are confused with manic-depressive psychosis. Thus, where the rate of schizophrenia is low, the rate of manic-depressive psychosis should be high. This assumption is immediately eliminated by the study of the statistics prepared by Bonfiglio (1952). In Calabria, Puglie, and Abruzzi, where the incidence of schizophrenia is low, the incidence of manic-depressive psychosis is also low (3.4 per 100,000 population for Puglie, 2.8 for Calabria, 4.5 for Abruzzi). In Calabria, for instance, the incidence of manic-depressive psychosis and schizophrenia together is 6.1 per 100,000; in Emilia it is 23.3 per 100,000. From an ethnic point of view, there has been such a mixture of racial groups and interchange of population from one region of Italy to another in the course of centuries that even those who attribute this illness to a purely hereditary congenital factor cannot resort to a racial explanation. In my opinion the difference in the incidence of schizophrenia has to be explained on a cultural and social basis.

Italy, like a few other countries, from a cultural or social point of view may be divided into two parts: the north and the south. The

differences between these two regions are even more marked than the differences between the North and the South in the United States. Milan can be taken as the city representing the culture of the north and Naples that of the south. Milan is like a little New York, a big urban center, highly mechanized, with an industrial population. It represents the industrial culture of the twentieth century and is not too different from American cities. Naples is entirely different. Although it is a big city, it is not nearly as industrialized or mechanized. The north of Italy is more representative of the Western industrial scientific culture of the twentieth century, whereas the south of Italy is more typical of Western culture prior to the industrial revolution. It is predominantly agricultural and rural. Even the north of Italy, however, is not as representative of twentieth-century Western culture as American cities are. I do not mean to imply here that the differences are due only to the presence or absence of industries but to all chains of cause and effect that are determined by the presence or absence of industry in society.

As seen in Table 2 and Figure 51, the incidence of schizophrenia in the United States in 1949 was greater by far than the incidence of schizophrenia in Italy (15.0 for the United States; 8.2 for Italy); also

the more urban, industrial, and mechanized the milieu was, the higher was the rate of schizophrenia. Thus in the United States the highest incidence was found in the District of Columbia (39.8) and the lowest in Kansas (4.7). Highly industrialized states and large urban centers generally have a high incidence. In the District of Columbia, New York, Rhode Island, and California, with high urban populations, the rate of schizophrenia was very high (a high admission rate in Arizona and New Hampshire is difficult to explain). The greater incidence in New York and California may also be due to another sociological factor: the large percentage of people who have emigrated from other states or countries.

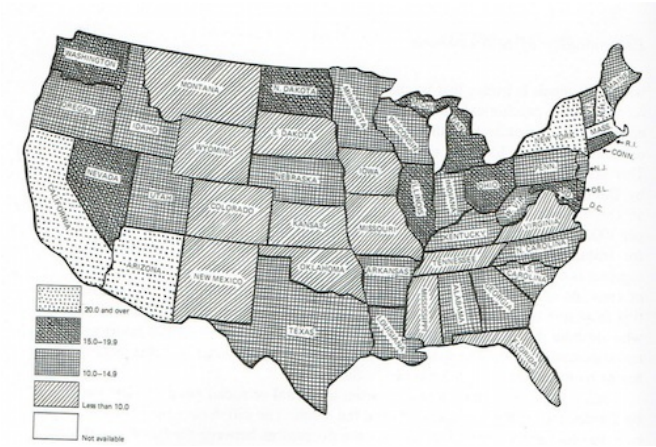

Figure 51

First admission rate for schizophrenia to state hospitals in the various states of the U.S. in the year 1949. The rate is per 100,000 inhabitants and is calculated on estimated 1949 population.

TABLE 2

First admissions of schizophrenic patients to state hospitals in the United States in 1949. The rate is per 100,000 inhabitants and is calculated on the estimated 1949 population, from data obtained from Patients in Mental Institutions, 1949, published by National Institute of Mental Health.

Alabama	13.9	Nebraska
Arizona	23.9	Nevada
Arkansas	10.5	New Hampshire
California	20.0	New Jersey
Colorado	7.4	New Mexico
Connecticut	19.0	New York
Delaware	19.2	North

		Carolina
Dist. of Columbia	39.8	North Dakota
Florida	8.5	Ohio
Georgia	10.3	Oklahoma
Idaho	12.4	Oregon
Illinois	18.3	Pennsylvania
Indiana	10.7	Rhode Island
Iowa	8.8	South Carolina
Kansas	4.7	South Dakota

Kentucky	11.7	Tennessee
Louisiana	13.8	Texas
Maine	13.0	Utah
Maryland	18.3	Vermont
Massachusetts*	—	Virginia
Michigan	16.4	West Virginia
Minnesota	12.7	Washington
Mississippi	8.3	Wisconsin
Missouri	9.4	Wyoming

Montana	6.1
United States	15.0

*No data were obtainable for Massachusetts.

Malzberg (1940) found that the incidence of schizophrenia among Italian-born persons who reside in the state of New York, although considerably lower than the incidence among those who emigrated from other European countries, was greater (30.4) than that of the native white population. This discrepancy is even more significant if we consider the fact that the majority of Italians who emigrate to the United States come from southern Italy, where the incidence of schizophrenia is the lowest. An Italian who emigrates from the region of Calabria to New York State increases his risk of being diagnosed a schizophrenic between nine and ten times. An immigrant from the islands of Sicily and Sardinia increases his risk five times, whereas an immigrant from Lombardy in the north of Italy increases his probability a little less than three times.

The importance of big urban centers may explain why in the

south of Italy, the regions of Campania-Lucania (which are calculated together) have the relatively high incidence of 7.9 per 100,000, whereas one would expect an incidence of 6 or less. This discrepancy is due to the presence in Campania of Naples, the biggest urban center of the south.

I believe it is important to interpret why in the United States and Italy, and probably in other countries, the incidence of schizophrenia is much greater in industrial-urban centers than in rural-agricultural areas.

There is no doubt that the roles of the home and family change with the transition from an agricultural, preindustrial society to an industrial one. In a society where no industrial revolution has taken place, the home is almost the exclusive center of interest. The father works in the home or on the farm or in the shop that is nearby or within walking distance. The home provides shelter, food, and education and takes care of the physical needs of the individual as well as the psychological needs. Relatives and close friends are welcome at any time. The social function of the family strengthens the ties between its members, and the intimacy of living together is

encouraged by a mass of physical activities. With the change to an industrial culture these activities are increasingly relegated to other agencies. The nursery school, the kindergarten, the school, the church, the bakery, the restaurant, the movies, the laundry, the clothing store, and many other institutions take over the functions of the home. Father has long ago stopped making tools at home for his trade; it is cheaper and more convenient to buy them when they are made by machines. Mother has to fuss less with the cooking, and even the sewing is reduced to a minimum. As we have already mentioned in Chapter 5, the family tends to become "nuclear."

In one respect, however, the family cannot change, that is, in providing for the emotional needs of the individual, which still must be satisfied. In an industrial society the satisfaction of these needs is made difficult by the lack of those activities that have been relegated to other agencies. The emotional interplay between the members of the family is sustained by a very fragile skeleton of social activities. The members of the household have relatively few contacts, do fewer things together, share fewer experiences, and are less willing to accept one another. Hostility that may exist among the members of the family is discharged during the few instances when the members meet and is

therefore much more traumatic. The destructive forces of the interpersonal conflicts come to the fore with more violence and are not diluted or softened by a large number of constructive acts.

The fact that the preindustrial culture obligates members to do things for one another increases the family's solidarity and in a certain way diverts the hostility of the individual to persons outside the family, for instance, to the gossiping neighbors or, in certain cases, to the inhabitants of the neighboring town. Without reaching paranoid proportions, this extrafamily discharge of hostility protects the family from its internecine effects.

A second factor, which is implied in the first, is that in an industrial society the family does not prepare the children as well for life as it did before. The leap from the nuclear family to the big world is not easy to make. When adolescence or youth is reached and the individual has to make his first excursions into life on his own, he feels less prepared and more dependent on the family. His insecurity increases even more if he has to depend on members of the family who are incapable of giving him a feeling of emotional security.

The third factor is the change in the role of the woman in the family. We have already discussed the great simplification of the physical functions of the home in an industrial culture. These functions are largely entrusted to the woman in a preindustrial society; in an industrial society the wife has very little to do and cannot be satisfied with just being a housewife. More and more often she wants to have a business or a professional career. Because her functions have been removed by the industrial revolution, she wants to be equal to men in a still predominantly patriarchal society. She sees herself more and more in the traditional role of a man and diverts her interests from the functions of the housewife (Thompson, 1941, 1942). There is one function, however, that most women neither can nor want to dispense with—motherhood. Here, many conflicts arise as a result of the confusion in this state of transition; whereas the woman has divested herself of many functions of the housewife, she must be as good a mother as she was before, although she has been allowed to become a poor housekeeper. She will follow the trends of the time and will try to divest herself of some of the other functions of motherhood. Thus, she will resort to artificial feeding instead of nursing and to the nursery school instead of taking care of the child herself. Often she prefers to

go to work and sends the child to the nursery school. If her mind has been oriented since childhood toward a career, her interests in motherhood may be relegated to a secondary role; she may actually resent the care she has to give to the child. On the other hand in the career world she feels discriminated against because of her gender. She is certainly justified in many instances, but her rancor may become hostility discharged at random.

In an industrial culture, motherhood is thus bound to lose some value, although a nostalgic longing for the old type of motherhood is strongly retained in the culture. When the mother, because of her own personal difficulties, has hostile and destructive tendencies, these will be more easily directed toward the children if she lives in a culture where motherhood does not have an almost exclusive importance in a woman's life. The father also loses some of his traditional roles and authority; he is insecure, competitive with his wife, and resentful. In this type of society, the family situations and parental attitudes that many authors have found in the majority of cases of schizophrenia (Chapter 5) may readily occur.

In a nonindustrial culture like that found in southern Italy, a

hostile, neurotic mother will be more inclined to develop psychosomatic symptoms or to direct her hostility toward herself or her husband rather than toward her children. The aura of sanctity that motherhood has, and the physical needs that she must constantly satisfy in the children, make the woman less inclined to discharge hostility toward them. Obviously there are some very hostile mothers even in a nonindustrial culture, but the incidence is less common than in an industrial one. On the other hand, the same nonindustrial culture leads more easily to other difficulties. The extreme closeness with parents leads to Oedipal situations and to psychoneuroses, both of which are based to a large extent on sexual repression. A nonindustrial society may assume an inner-directed character and thus predispose to manic-depressive psychosis (Arieti, 1959). We shall state in passing here that the industrial culture corresponds in many ways to what Reisman has called other-directed (Reisman et al., 1950).

It is not very difficult now to understand also why the incidence of schizophrenia should increase in big urban centers. In fact, all the characteristics of an industrial culture become more and more accentuated with the increase in population. We have seen, however, that even in nonindustrial societies agglomeration of people in urban

centers increases the percentage of schizophrenia, although not in a pronounced manner. In big cities space diminishes—children have less space in which to play, are more confined, and are more at home under the influence of their parents. In big cities, as was mentioned before, home life becomes less meaningful, and yet the child is compelled to stay at home much more than he would in rural areas. At the same time, the factors studied by Faris and Dunham (1939) also operate.

VI
Concluding Remarks

Almost all the sociological factors that we have studied in this chapter may either facilitate or make more difficult the occurrence of schizophrenia because of their direct or indirect psychological impact. Whatever is sociological must affect sooner or later the human psyche in order to favor or hinder the occurrence of the psychosis. Statistics and data remain numbers and physical facts until we are able to interpret them in terms of human suffering, aggravating circumstances, improvement, and relief.

Adverse social factors may have a psychological effect at various

times in a person's life. Early in life, the psychological effect consists of a certain degree of disturbance, disorganization, or stress of the family milieu. The social factors engender, add to, or make it more difficult to compensate for, those intrafamily psychodynamic conflicts described in Chapters 5, 6, and 7. It is plausible to think that parents living in societies where inequalities, poverty, exploitation of any kind, persecution, discrimination, or false values prevail suffer in their personality structure and consequently offer poor parenthood to their children in a larger percentage than parents living in more satisfactory societies.

Throughout the life of the individual, social factors may have a psychological effect, not by eliciting special psychodynamic patterns, but merely as stress factors. In these cases the sociological factors act as adjustment hazards; that is, they represent adverse psychological pressures on the individual that cause him to be under greater strain, with the result that his psychic reserves, which might have neutralized the schizophrenogenic variables, are no longer sufficient.

When society at large engenders, adds to, or makes more probable or more virulent some destructive trends of the early family

environment, the defenses against psychoses may break down more easily. On the other hand, a favorable social environment may compensate for the unfavorable psychodynamic development or even for some hereditary predisposition and make the psychosis less likely to occur. It remains more than doubtful that the social and other epidemiological factors mentioned in this book will be able to engender schizophrenia in the absence of the hereditary predisposition mentioned in Chapter 27. But this hereditary predisposition is quite common. It is also doubtful that these factors could cause the disorder in the absence of the psychodynamic processes illustrated in Part Two. But, as we have just mentioned, most of the adverse social factors make more probable or intensify these psychodynamic processes.

Notes

[1] A similar hypothesis has been advanced by American authors who thought that the increase in first admission rate occurring in New York State was due to the fact that relatives had become more willing to hospitalize patients. Malzberg (1940) analyzed this point and concluded that although this changed attitude toward hospitalization may have had some bearing on the rate of admission, it could not explain entirely the large increase in the incidence of mental patients admitted to hospitals.

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