INTERPRETATION OF SCHIZOPHRENIA

First Period:
Early Childhood and Family Environment

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I
Introductory Remarks

The *beginning* of the manifest symptomatology of schizophrenia, described in the previous part of this book, represents also an end—the end of a nonpsychotic but special personal history that started much earlier, in some cases even at the moment the patient was born. This history has to be studied not merely as a sequence of events, but in its developmental impact and multiple interconnections. In other words, it becomes the subject of a study of psychological forces, *a.psychodynamics.* I do not imply that psychological forces cease to exist once the manifest symptomatology begins. They only change channels and mechanisms as they become conveyed predominantly through psychotic symptoms. In Part Two we shall discuss the psychodynamics of the life of the patient prior to the psychosis, as well as during the initial psychotic stage.

A characteristic unique to the human race—prolonged childhood

with consequent extended dependency on adults—is the basis of the psychodynamics of schizophrenia. What occurs at any subsequent age is also relevant and may bring about the decisive turns of events that trigger the psychosis. The childhood situation, however, provides preparatory factors that have a fundamental role inasmuch as they may narrow the range of choices of life directions, thwart the possibility of compensation, determine basic orientations, and facilitate abnormal sequences of events.

A psychodynamic understanding of any human being and, in our particular case, of a person who will eventually suffer from schizophrenia, requires that we study the following:

1. The world which the child meets.

2. The child's way of experiencing that world, especially in its interpersonal aspects.

3. The way the child internalizes that world and the effects of such internalization.

4. The ways by which the sequence of later experiences weaken, reinforce, distort, neutralize, expand, or restrict the effects of the early experiences.

Prolonged childhood implies a prolonged state of physical, emotional, and cognitive immaturity with which the child meets the environment, experiences it, and internalizes it. The function of internalization requires some explanation. Starting from approximately the ninth month of life the baby retains in his psyche the mental representations of the persons who are involved with him and of the events or situations that occur in his small environment. These mental representations, usually called *inner objects,* will constitute more and more his psychological life. This inner life, or inner reality, may represent, substitute, distort, enrich, or impoverish the reality of the external world. It becomes the essence of the individual.

Inner reality is the result of a constant reelaboration of past and present experiences. Its development is never completed throughout the life of man, although its greater rate of growth occurs in childhood and adolescence. It is based on the fact that perceptions, thoughts, feelings, actions, and other psychological functions do not cease to exist completely once the neuronal mechanisms that mediated their occurrence have taken place. Although they cannot be retained as they were experienced, their effects are retained as various components of

the psyche.

Although this inner life, or inner self, has an enduring life of its own, it should not be considered a closed system. It has many exchanges with the environment. Psychodynamics thus involves the study of the intricate interplay and mutual dependence between interpersonal relations and inner life. In other words, it implies the study of what is interpersonal as well as intrapsychic in the individual. In this chapter and in the following ones we shall at times focus on the patient's inner life; at other times we shall focus on his environment, especially the family environment, in order to show how the two aspects of his life interrelate. This alternation may appear in some cases as a strident contrast, but it is by correlating the two aspects of the human psyche that we can reach an adequate psychodynamic understanding.

I have found it useful to divide the psychodynamic development of schizophrenia into four periods, of which only the last one can be considered psychotic.

The first period extends from birth to approximately the time

when the child enters grade school. The second period covers late childhood, or that period which in Freudian literature is referred to as the latency period. The third period generally starts around the time of puberty, but it may start much later. The fourth period starts with the beginning of the psychosis.

The present chapter will deal with the different phases of the first period.

II
The First Few Months of Life

During the first six or seven months inner life is rudimentary. The psychology of the baby to a large extent can be understood in terms of simple physiological mechanisms, immediate interpersonal contacts, and what Piaget calls sensori-motor intelligence. The baby probably has a primitive kind of identity that includes his motor behavior, the awareness of his body and his contacts with the immediate external world. Although the baby is already able to experience many events inside and outside his body, the parts of the central nervous system that permit the retention of images and the recall of past experiences have not yet matured. He functions at a sensori-motor level.

Like the newborn of many species he is helpless and dependent on parental care for survival. He has certain needs, like food, sleep, rest, warmth, and contact with the body of mother, that must be satisfied. When these needs are met, a state of *satisfaction* occurs. The lack of satisfaction of these needs brings about a state of discomfort that may be designated as tension, deprivation, or a relatively simple state of anxiety similar to the one that is also experienced by subhuman animals in similar conditions.

More complicated events, however, do take place even in the life of the few-month-old baby. The contact with the mother, for instance, acquires a great significance already from birth. The nursing situation is not just a mechanical nipple-in-lips situation, or just a gratification of appetite or of a sucking need, but includes the experiencing of a primitive, presymbolic, immediate empathic tenderness of the mother. It is important to stress that although abnormalities may already exist at this age in the baby and in the relation with his mother, they are not those that are directly responsible for a subsequent adult schizophrenia. This point is emphasized because in spite of abundant evidence to the contrary (Fromm-Reichmann, 1952; Arieti, 1955; Lidz et al., 1965), some authors continue to consider the schizophrenic

disorder to be a “fixation at the oral stage.” Certainly some abnormal conditions occurring in the first few months of life may lead to other abnormalities that in their turn may be schizophrenogenic. The baby may be in a state of altered homeostasis, discomfort, or deprivation, but does not experience a state of conflict, either intrapsychic or interpersonal. Among the possible deprivations, we must underline the absence of a tender human being. Some authors (Spitz, 1945, 1965; Bowlby, 1951, 1960) have described severe psychopathology, like depression, in the first year of life, following separation from mother. It is doubtful that this “depression,” no matter how unpleasant and disturbing, is the same syndrome as the depression of the adult. The infant cannot conceptualize such ideas as abandonment, death, irreparable loss, and hopelessness, and therefore cannot experience the feeling that leads to a depression. A relation between maternal deprivation in the first few months of life and adult schizophrenia is even more uncertain. In my many years of clinical experience I have ascertained only one case in which this relationship existed—namely, a girl who sustained probably great deprivation when the parents left for an extended vacation when she was 9 months old. This girl subsequently developed separation anxiety, school phobia, and, by the

time of puberty, a very schizoid personality bordering on simple schizophrenia. Because this is the only case of this type, it is not statistically significant, even in the range of my experience. Moreover, this girl underwent this deprivation when she was 9 months old; and I am referring here only to the first 7 or 8 months of life.

However, if a child has been exposed to a depriving environment in the first few months of life, the probability is great that he will be exposed to an adverse or schizophrenogenic environment after the ninth or tenth month. The reverse, however, is not true. Many parents of schizophrenics were able to fulfill more or less adequately their parental role when the child was a baby, a completely dependent entity not yet showing signs of autonomy. The baby, as a matter of fact, may have been treated with constant and scrupulous care, and with some kind of tenderness and concern, as a pet or a doll. In these cases no serious difficulties arise until later when the child becomes an autonomous individual in his own right, with wishes and wants that are discordant from those of the parents. It is at this stage that motherhood may become defective.

A different observation made in a minority of cases is worthy of

consideration. Some relatives of schizophrenics have reported that there seemed to be something wrong with the child from the very moment of birth. The baby appeared nervous, would cry all the time, had feeding problems, and so on. Later, but still in early childhood, he was a child impossible to take care of. “Even a saint could not have been able to take care of him.” Again it is impossible to determine whether these characteristics of the child originated in the child or were a reaction to the anxiety or hostility of the mother. It could very well be, however, that some children deviate slightly from the normal. They are irritable, cry excessively, and have difficulties in adapting to environmental situations. Whereas the average mother is able to adjust to these deviations of the child, the mother of the future patient is not. She becomes increasingly alarmed and anxious and responds to her anxiety, not with greater care, but with poor motherhood. A vicious circle, or a two-way stream results. Most probably the majority of these so-called impossible children are children with minimal brain damage and are consequently hyperkinetic (see Clements, 1966; S. Levy, 1966; Werry, 1968). Fortunately the majority of these children outgrow their symptoms or at least ameliorate them later on. It could be, however, that a certain number of them elicit in the mother a state

of anxiety and despair that in its turn may affect adversely the child, even with schizophrenogenic effects.

For the vast majority of cases of adult schizophrenia it is more important to study what happens to the child during and after the last quarter of the first year of life. Contrary to what happens in other species, the human child continues to be dependent on others; moreover, from now on he will require not only satisfaction of needs but also a feeling of *security.* We owe to Sullivan (1953a) the differentiation between satisfaction and security.

The capacity to experience security or to suffer from the lack of it requires a degree of psychological organization that is more complicated than that occurring in the first few months of life. The relations with the adults who take care of the child are very important in this respect. Thus, at this point we shall interrupt the study of the child, and we shall take into consideration the family of which he happens to be a member.

III
The Family Environment

The reader must be aware that the studies of the family of the schizophrenic patient were made after the patient became sick and in most cases had grown to be an adult. The assumption is made that the study of how the family is at the time of the illness, together with the past history, may give us an adequate picture of how the family environment was during the time preceding the psychosis. This is, however, only an assumption. All in all, some conclusions may be justified, but the degree of accuracy is questionable. This is the only type of inquiry that was done so far. Thus, although this chapter is devoted to the very early environment of the future patient, most of the characteristics we are going to describe pertain even more to the family of the patient as it was in subsequent periods. There will be here, therefore, some chronological irregularities in our exposition, which are due to the present status of our knowledge of this matter.

Among the experiences that psychiatrists very vividly remember about their residence training are their first encounters with members of the family of the schizophrenic. It is relatively easy for the trainee to conclude that this family is not a happy one, and that its unhappiness is not merely connected with the patient's present illness. It could be traced back to the formative years of the patient. This unhappiness,

although aggravated at times by realistic situations (poverty, physical illness, disappointments of various kinds), is as a rule grounded in personality factors. The disharmonious marriage of the parents looms prominent among these factors. As we shall see later in greater detail, the marriage is unhappy not only because of the incompatibility of the parents, but also because their personal difficulties, rather than being ameliorated by compensatory mechanisms, were aggravated in the process of living together. In families of nonschizophrenics, marital unhappiness is also very common, but it is not allowed to interfere so diffusely or so deeply with the upbringing of the children. For instance, the unhappily married mother may genuinely learn to expect life fulfillment in motherhood. Although this compromise is not satisfactory, it may be of some value, especially when supported by the prevailing cultural or societal mores. It does not remove all psychological difficulties of the children, but may prevent the most serious ones.

The atmosphere of unhappiness and tension, although all pervading and pronounced in the family of schizophrenics, in many cases is not apparent to the casual observer, because an attempt is made by all concerned to conceal it not only from the external world,

but also from themselves. At times it is almost totally repressed and replaced by psychological insensitivity. The psychiatrist in training learns also to recognize the anxiety-ridden parents who are motivated by a strong unconscious guilt feeling. These parents exert pressure on the physician, trying to get reassurance from him that everything possible is being done to restore the patient's health. Often the doctor wishes to alleviate this guilt feeling and tries to reassure the parents —"You should not feel responsible; schizophrenia is a mysterious disease; it can happen to everybody." But the parents are generally not reassured.

In a vague way, or in the form of a feeling that cannot be very well verbalized and therefore gives the impression of being irrational, they sense that they have played a role in their child's illness. These guilt feelings often lead parents to irrational actions. In a vain attempt to undo what they feel they have done, they may take the patient home from the hospital in spite of obvious contraindications. Consequently the activities of the family are thwarted or actually paralyzed, and care of minors at times is curtailed because of the enormous amount and unusual kind of care that a very ill person requires at home.

At other times it is obvious to the young psychiatrist that a great deal of love for the patient existed, but that this love had not been utilized by the patient because it was mixed with a great deal of anxiety.

These rather simple clinical observations made by several generations of psychiatrists have rightly been considered insufficient to evaluate the family of the patient. Thus many authors have tried to go more deeply into this matter. One group of authors has studied the family by means of the treatment of the patient himself, that is, they relied greatly on how the patient portrayed his own family. Another group of authors, starting with the pioneer work of Theodore Lidz, has studied the family of the patient independently.

The first group of authors has concluded almost unanimously that the mother is the main dynamic factor in the genesis of the child's future psychiatric condition. Some of these authors have followed Fromm-Reichmann (1948) in referring to the mother of the patient as "schizophrenogenic." They have described her as overprotective, hostile, overtly or subtly rejecting, overanxious, cold, distant, and so forth. Because of these characteristics she was unable to give herself to

the child and was unfit for motherhood. Sometimes she tried, but she did not know how. John Rosen referred to her perverse sense of motherhood. In the writings of a large number of authors she was described as a malevolent creature and was portrayed in an intensely negative, judgmental way (Sullivan, 1953a, 1964; Rosen, 1962, 1963; Hill, 1955; Limentani, 1956; Bateson et al., 1956; Lu, 1961; Lidz, et al., 1965). Reichard and Tillman (1950a) quote in addition to their own research a long list of works in which this negative parenthood was illustrated.

Searles (1958) is in a small minority in finding something positive in the relationship between the schizophrenic and his mother.

As already mentioned, a second group of authors wanted to determine whether the picture of mother and father given by the patient could be confirmed by studying the family. Alanen (1958) studied a hundred mothers of schizophrenic patients and found that more than one-half of these mothers were suffering from personality disorders that were, in his opinion, more severe than psychoneurotic. Many of these mothers presented near-psychotic and schizoid traits. Alanen described an attitude that he called *the schizoid pattern of*

interpersonal relationship. He wrote:

> Such an attitude is characterized especially by a tendency to domination, which does not have any understanding for the child's own needs and feelings; but often at the same time also to powerful possessiveness, which all is quite particularly likely to suppress the child's possibilities to develop into an independent person and to tie him up to an authority which is inimical to his own self. In many cases one had to assume that the root of such an attitude was an anxious, ambivalent hostility which the mother felt toward her child, and in the generation of which, in turn, the hardships the mother herself had met during her life and especially in connection with her marital conflicts, had contributed their effect.

Alanen added that it often seemed "as though the mothers had made their children experience as doubled the frustrations they themselves had experienced."

Lidz too has confirmed the patient's negative appraisal of his mother.

The father of the schizophrenic patient has also been studied by Lidz and his associates (1957b). Whereas previous authors had emphasized the weakness, aloofness, and ineffectiveness of the father

in the paternal role, Lidz and associates describe him as insecure in his masculinity and in need of great admiration for the sake of bolstering his shaky self-esteem. Not infrequently he was found paranoid or given to paranoid-like irrational behavior and just as impervious as his wife to the feelings and needs of others.

Mostly because of the influence of the pioneer work of Ackerman (1954, 1958), the family has come to be studied as a unit, or a constellation, having an impact on the future patient that is greater than the sum of the effects of the individual members. For instance, it is not just the attitude of the mother toward the child that has to be taken into consideration, but also how the attitude of the mother affects the whole family, and how the result of this attitude toward the whole family indirectly affects the child. Vice versa, it is also important how each member of the family interacts with each other, and how, in consequence of this interaction, each one, or most of them, or all of them will act toward the individual child. In other words, we are not dealing exclusively with relatively simple one-to-one relationships. More complicated multiple interactions take place. To give a concrete example, the mother is not just the mother of little John, but is also the person who, while she is dealing with John, is affected by the father, by

the other children individually, by the whole family, and by John himself. All these intricate relations are difficult to disentangle and study separately. By definition, they cannot be completely separated. Jackson (1967b) made the pertinent observation that families of schizophrenics are not disturbed in the usual sense attributed to this word, nor are they disorganized. On the contrary, the schizophrenic family is more highly organized than the normal family, in the sense that "such a family utilizes relatively few of the behavioral possibilities available to it." According to Jackson, the bizarre, maladaptive behavior of the family is an indication of a restriction of the behavioral repertory that does not allow variations or other rules to be followed.

Many authors have described special family constellations in schizophrenics. In the first edition of this book I have described one family constellation, which I frequently encountered in two varieties (Arieti, 1955). The first was when a domineering, nagging, and hostile mother, who gives the child no chance to assert himself, is married to a dependent, weak man, who is too weak to help the child. The father does not dare protect the child because of fear of losing his wife's sexual favors, or simply because he is not able to oppose her strong personality. By default, more than by his direct doing, he has an

adverse effect on the child.

Occurring less frequently in the United States, but still frequently enough, is the second, opposite, combination: a tyrannical or extremely narcissistic father is married to a weak mother, who has solved her problems by unconditionally accepting her husband's rules. These rules do not allow her to give enough love to the child or to be considerate enough of his affective requirements. In these families, the weak parent, whether mother or father, becomes antagonistic and hostile toward the children because she (or he) displaces her (or his) anger from the spouse to the children, as the spouse is too strong to be a suitable target.

Lidz and associates (1957a) also described this type of family constellation and gave it the name *marital skew.* At the same time, they described what they called *marital schism* (Lidz et al., 1957a). They found that in this case the role of each spouse in the family cannot be well established and that no attempt is made by them to complement or to help each other. There is no possibility of getting together and no reciprocal understanding, cooperation, mutual trust, or confidence; instead, there is only rivalry, undercutting of worth, threat of

separation, and enrollment of the children's support against the other. Each partner is disillusioned with the other: the husband sees the wife as a defiant and disregarding person who also fails as a mother; the wife is disappointed because she does not find in her husband the father she expected for her child. It is in this background that the family becomes split into two factions by the overt marital schism of the parents. Generally the children belong to one side of the schism or to the other and have to contend with problems of guilt because of their divided loyalty.

I have found other frequent constellations. One of them consists of a family in which each member is intensely involved with the others. Each member experiences not just a feeling of competition with the others, but an extreme sense of participation, reactivity, and sensitivity to the actions of the others, often interpreted in a negative way. In these cases the members of the family want to help each other, but because of their neurotic entanglement, anxiety, distrust, and misinterpretation, they end up by hurting one another. They remind one of some plays by Chekhov or other authors in which the limitations of the characters' personalities and their morbid involvement with one another lead gradually to disaster.

I have observed also a different type of family, which is almost the opposite, or perhaps a reaction formation, of the one described. The family can be compared to an archipelago. Each member lives in emotional isolation and communicates very little with the others, in spite of physical proximity.

Other authors have reported different patterns of abnormal interaction. For instance, according to Wolman (1966) the following situation occurs. Normally intraparental relationships are mutual, that is, they are characterized by giving and taking. The parental attitude is *vectorial,* which means giving and protecting. The child's attitude is characterized by taking. According to Wolman, in the family of the schizophrenic neither father nor mother is vectorial. The mother requests love from the child and the father assumes the role of a (1) sick, (2) prodigy, (3) rebellious, or (4) runaway child. The father competes with the child, who is forced to assume a protective hypervectorial attitude toward the parents. The child worries about his parents and is terror stricken. This emotional disturbance leads to schizophrenia, which Wolman renames *vectoriasis praecox.*

In evaluating these families in a general way, Lidz and Fleck

(1964) wrote of the possibilities of something being fundamentally wrong with the capacities of the "parents to establish families capable of providing the integrative development of their offspring." They spoke more specifically of three categories of deficiency: (1) poor parental nurturance; (2) the failure of the family as a social institution; and (3) inadequate transmission of the communicative and other basic instrumental techniques of the culture. Lidz and co-authors (1958) speak also of the irrationality of the parents being transmitted directly to the patient. Some delusional or quasi-delusional conceptions of the parents are reported by these authors as accepted by the patient, without further elaboration, just as happens in *folie a deux* (see Chapter 11). As a matter of fact, Lidz speaks of *folie a famille* in the family of the schizophrenic.

An important problem that has interested authors who have studied family processes in schizophrenia is the persistence of these abnormal interaction patterns (Mishler and Waxier, 1968). An outsider is generally inclined to believe that if a pattern of living leading to undesirable results has been formed in a family, the pattern would be corrected and equilibrium restored. The opposite, however, occurs in the family of schizophrenics. The same unhealthy

"homeostasis" at times lasts decades. Haley (1959) writes:

> If a family confines itself to repetitional patterns within a certain range of possible behavior, then they are confined to that range by some sort of governing process. No outside governor requires the family members to behave in their habitual patterns. . . . When people respond to one another, they govern, or establish rules, for each other's behavior. . . . Such a system tends to be error-activated. Should one family member break a family rule, the others become activated until he either conforms to the rule again or successfully establishes a new one.

Many authors see the future schizophrenic as assuming in the family structure the role of scapegoat, or as a responsible ally of one parent. This role maintains the pathogenetic interaction patterns of the whole family. Searles (1958) and Wolman (1966) believe that the child maintains the morbid role because he loves mother and wants to give to her. He believes that without him she would be in a disastrous situation.

As I shall illustrate in various parts of this book, I believe that circular patterns are created that not only maintain the abnormal pathogenetic family structure, but also make it worse and more rigid.

IV
Conclusions about the Family of the Schizophrenic

I shall offer now my own evaluations and conclusions about the above findings. Some readers will recognize that in some aspects my points of view have changed since the first edition of this book was published.

1. The findings described in the previous section indicate that turbulent conflict, tension, anxiety, hostility, or detachment generally existed in the family of the patient since his formative years. However, we must be aware that these findings cannot be subjected to statistical investigation. It is often an enormous task to evaluate qualitatively or quantitatively the psychological disturbance existing in a family. One must keep in mind that a minority of authors (for instance, Waring and Ricks, 1965) have found the above described specific family constellations less frequently among schizophrenics than in control studies.

2. It is common knowledge that similar family disturbances exist even in families in which there has not been a single case of schizophrenia within the two or three generations that could be investigated.

3. It is not possible to prove that the adult schizophrenics studied in family research were potentially normal children whose lives were warped only by environmental influences.

4. The only point of agreement of most authors who have studied schizophrenic patients psychodynamically is that *in every case of schizophrenia studied serious family disturbance was found.* Unless biases have grossly distorted the judgment of the investigators, we must believe that serious disturbance existed.

5. This conclusion is important. It indicates that although serious family disturbance is not *sufficient* to explain schizophrenia, it is *presumably a necessary condition.* To have differentiated a necessary, though not sufficient, causative factor is important enough to make this factor the object of our full consideration.[1]

6. I have revised the concept of the so-called schizophrenogenic mother. We have seen that the mother of the schizophrenic has been described as a malevolent creature, deprived of maternal feeling or having a perverse sense of motherhood. She has been called a monstrous human being. At times it is indeed difficult not to make these negative appraisals, because some of these mothers seem to fit that image. Quite often, however, an unwarranted generalization is made. The mother of the patient is not a monster or an evildoer,

> but a person who has been overcome by the difficulties of living. These difficulties have become enormous partly because of her unhappy marriage, but most of all because of her neurosis and the neurotic defenses that she built up in interacting with her children. Moreover, we must take into account the fact that the studies of these mothers were made immediately preceding the era of women's liberation. In other words, it was a period during which the woman had to contend fully, but most of the time tacitly, with her newly emerged need to assert equality. She could not accept submission any longer, and yet she strove to fulfill her traditional role. These are not just social changes; they are factors that enter into the intimacy of family life and complicate the parental roles of both mothers and fathers.

We must add that this was the time when the so-called nuclear family, an invention of urban industrial society, came into its full existence. The nuclear family consists of a small number of people who live in little space, compete for room, for material and emotional possession, and are ridden by hostility and rivalry. The home is often deprived of educational, vocational, and religious values. The nuclear family is frequently destructive not only for the children but for the parents too.

In the last fifteen years I have compiled some statistics that differ from what other authors have reported and what I myself described in the first edition of this book. Although personal biases cannot be excluded, and the overall figures are too small to be definitive, I have reached the tentative conclusion that only 25 percent of the mothers of schizophrenics fit the image of the schizophrenogenic mother.[2] Why then have so many different authors generalized to all cases what is found in a minority of apparently typical cases?

Of course there is the possibility that I have not recognized what was not apparent. However, it is hard for me to believe that later in my psychiatric work I have grown insensitive or less aware of the intangible and subtle dynamics. Repeated observations have led me to different tentative conclusions. As we shall see in greater detail in Chapter 38, schizophrenics who are at a relatively advanced stage of psychodynamically oriented psychotherapy often describe their parents, especially the mother, in negative terms. Therapists, including myself, have believed what the patients told us. Inasmuch as a considerable percentage of mothers have proved to be just as they were described by the patient, we have considered this percentage as typical and have made an unwarranted generalization that includes all

the mothers of schizophrenics. The therapists of schizophrenic patients have made a mistake reminiscent of the one made by Freud when he came to believe that neurotic patients had been assaulted sexually by their parents. Later Freud realized that what he had believed as true was, in by far the majority of cases, only the product of the fantasy of the patient. The comparison is not exactly similar, because in possibly 25 percent of the cases the mothers of schizophrenic patients have really been nonmaternal, and we do not know what percentage of mothers of nonschizophrenics have been nonmaternal.

If this conclusion is correct, we must inquire why many patients have transformed the image of the mother or of both parents into one that is much worse than the real one. As we shall see later in the sixth section of this chapter, the answer to this problem will be provided by the intrapsychic study of the patient, especially in his early childhood.

V
Early Development

In order to understand the abnormalities in the development of the future schizophrenic, it is important to present a brief account of

some developmental aspects in normal early childhood.[3]

Toward the end of the second section of this chapter we saw that in order to continue to grow normally after the first nine-twelve months, the human being needs, in addition to a state of satisfaction, a state of security. Before the others acquire “a significant” or symbolic importance, the life of the child is governed almost entirely by simple psychological mechanisms.

Things are taken for granted by the infant; they are expected to occur, as they have occurred before. After a certain stimulus (hunger, for instance) a subsequent act (the appearance of the mother’s breast) is expected. Later the child comes to feel that all things in life are due to others or depend on others. It is up to mother to give him the breast, to keep him on her lap, to fondle him. The child learns to see everything in a teleologic way—everything depends on the will or actions of others. But together with the feeling that everything depends on others, there is also the feeling that people will do these wonderful things. In other words, the child expects these wonderful things to happen; he trusts adults. At first, of course, these feelings of the child are vague and indefinite. Because the child is deprived of the

use of abstract words to describe these phenomena, his expression of these feelings remains at a primitive level. We may describe them as diffuse feelings, postural attitudes, physiological preparation for what is expected, nonverbal symbolism, and so forth. Security does not consist only of removal of unpleasant emotions or removal of uncertainty, but also of pleasant anticipation, a feeling of well-being, a trust in people and in things to come. Year-old children experience security in their contacts with the mother if she is not anxious, hostile, or prevented by other causes from mothering the child.

This feeling of security, at least in its early stages, corresponds to what Buber (1953), Erikson (1953), and Arieti (1957b) have in different contexts called trust or basic trust. Basic trust or security is a feeling that is elicited in proximity to some other human beings. Although occurring in connection with various interpersonal relations, it is experienced intrapsychically. As we shall see later, security starts to be fully experienced later in childhood, when higher cognitive processes permit reflected appraisal and the building of self-esteem. The need for security will remain constant throughout the life of the individual, although it will assume different aspects in different ages.

In a subsequent phase the child also expects approval from others. That is, the child expects the significant adults to expect something of him; the child *trusts* that the adults will *trust* him. In other words, there is a reciprocal trust that things are going to be well, that the child will be capable of growing up to be a healthy and mature man or woman. The child perceives this faith of the mother and accepts it, just as he used to accept the primitive responses to the usual stimuli. He finally assimilates the trust of the significant adults, and he *trusts* himself (Arieti, 1957b). Thus, things will no longer depend exclusively on others, but also on himself.

This feeling of trust in oneself and this favorable expectancy, which at first is limited to the immediate future, becomes extended to the immediate contingencies of life and then expands into a feeling of favorable anticipation as far as a more or less distant future is concerned. A basic optimism, founded on basic trust, is thus originated. Security then will consist of all these feelings. If we consider this feeling of security or basic trust in its more social or interpersonal aspect, we may state that its interpersonal counterpart is what can be called a state of *communion.* [4]

This atmosphere, first of satisfaction, then of security and communion (at least with the mother), facilitates the introjection in the child of the symbolic world of the others. It is this introjection that actually permits the emergence and the growth of the self, especially the introjection of the attitudes, feelings, verbal symbolisms, and so forth, emanating from the mother.

Using Buber's useful terminology and conceptions, we may say that an I-Thou relationship exists. Psychologically, this means that without others and trust in them there would be no I, no development of the self.[5]

It is toward the end of the first year of life, generally from the ninth month, that through internalization the child starts to build an inner life, or psychic reality, which is a counterpart to the external reality with which he is involved. Internalization occurs first through cognitive mechanisms belonging predominantly to what Freud called the primary process, and later more and more to what Freud called the secondary process. Freud originally described the primary process as it occurs in dreams. He called this process "primary" because according to him it occurs earlier in child development, and not

because it is more important than the secondary. The secondary process develops later and employs the usual normal cognitive processes of the adult awake mind. Whenever complex recognition, differentiation, deduction, and induction are used, the secondary process is necessary.

Both primary and secondary processes use symbolic cognitive mechanisms. Contrary to more primitive nonsymbolic methods, like simple learning directly associated with perceptions or with what is immediately given, the primary and secondary processes open up a symbolic world to the child, that is, the representation of what is absent, potentially absent, or imagined.

The child continues to participate in the world through nonsymbolic ways, like simple or direct learning derived from perceptions, conditioned reflexes, and so forth. Soon, however, he develops symbolic mechanisms, the most primitive of which constitute what I have called primary cognition. They are images, endocepts, and paleologic thinking.[6] Except in pathological conditions, these primitive mechanisms are replaced and overpowered by more mature secondary processes. They occur also in normal adult life, but it is

difficult to find pure forms of them in adults or even in children if they are normal.

The image is a memory trace that assumes the form of a representation. It is almost an internal reproduction of a perception that does not require the corresponding external stimulus in order to be evoked. The image is indeed one of the earliest and most important foundations of human symbolism, if by symbolism we mean something that stands for something else that is not present. From now on cognition will rely also on what is absent and inferred. For instance, the child closes his eyes and visualizes his mother. She may not be present, but her image is with the child; it stands for her. The image is obviously based on the memory traces of previous perceptions of the mother. The mother then acquires a psychic reality not tied to her physical presence.

Image formation introduces the child into that inner world which I have called fantasmic (Arieti, 1967). The image becomes a substitute for the external object; it is a primitive inner object. In a considerable number of children the image is eidetic; that is, particularly vivid, almost indistinguishable from perception. The predominant use of

images, especially eidetic ones, may cause in young children what Baldwin (1929) called *adualism,* or at least difficult *dualism:* that is, an inability to distinguish between the two realities, that of the mind and that of the external world. This condition may correspond to what orthodox analysts, following Federn (1952), call lack of ego boundary.

Another important aspect that very young children may retain from the sensorimotor level of organization is the lack of appreciation of causality. The child cannot ask himself why certain things occur. He either naively accepts them as just happenings, or he expects things to take place in a certain succession, as a sort of habit rather than as a result of causality or of an order of nature. The only phenomenon remotely connected with causation is a subjective or experiential feeling of expectancy, a feeling that is derived from the observation of repeated temporal associations.

The endocept is a mental construct representative of a level intermediary between the one characterized by the prevalence of images and the one characterized by language. It derives from memory traces, images, and motor engrams. Its organization results in a construct that does not tend to reproduce reality and that remains at a

nonrepresentational, preverbal, and preaction level. It is just a disposition to feel, to act, to think and is accompanied by a vague awareness and at times undefinable, diffuse emotions.

Paleologic thinking occurs for a short period of time early in childhood, from the age 1 to age 3. It is a way of thinking that seems illogical according to adult standards or normal logic. As we shall see in greater detail later, it is based on a confusion between similarities and identities. A salient part or characteristic that two persons or objects have in common is enough to make them appear identical, or belonging to the same category or class—formation of primary classes (Arieti, 1963b). All pictures of men are "daddies" because they look like daddy.

Normal maturation controls the inhibition of these primitive forms and enhances the replacement by mature or secondary forms of cognition. That young children have greater difficulty in dealing with objects similar to those already known to them, than they do with objects completely unknown, has been recently confirmed by Kagan (1972), who formulated the discrepancy principle. As a result of the infant's encounters with the environment he acquires mental

representations of events, called schemata. Events that are moderately different from an infant's schema (or discrepant events) elicit longer spans of attention than either totally familiar events or totally novel events. For instance, in one experiment the child was shown a two-inch orange cube on six separate occasions. The infant was shown either a smaller orange cube (a discrepant event) or a yellow rippled cylinder (a novel event). Kagan reports that infants between 7 and 12 months old became excited by the discrepant small cube, whereas they were not disturbed by the appearance of the novel rippled cylinder. Discrepant objects or events are similar. A tendency exists in children to overcome the problem of how to deal with similar events by reacting to them as if they were identical (paleologic structure). Normal maturation regulates the inhibition of all these primitive forms of cognition as well as their replacement by mature or secondary forms.

Young children soon become aware of causality and repeatedly ask "why." At first causality is teleological: events are believed to occur "because" they are willed or wanted by people or by anthropomorphized forces.

We should not conclude that young children *must* think paleologically; they only have a propensity to do so. Unless abnormal conditions (either environmental or biological) make difficult either the process of maturation or the process of becoming part of the adult world, this propensity is almost entirely and very rapidly overpowered by the adoption of secondary process cognition. Moreover, children may still deal more or less realistically with the environment when they follow the more primitive type of nonsymbolic learning that permits a simple and immediate understanding. In secondary process cognition the individual learns to distinguish essential from nonessential characteristics and develops more and more the tendency to put into categories subjects that are indissolubly tied to essential characteristics.

The randomness of experience in early childhood is more and more superseded by the gradual organization of inner constructs. These constructs continuously exchange some of their components and increase in differentiation, rank, and order. A large number of them, however, retain the enduring mark of their individuality. Although in early childhood they consist of the cognitive forms that we have described (images, endocepts, paleologic thoughts) and of their

accompanying feelings, they become more and more complicated and difficult to analyze. Some of them have powerful effects and have an intense life of their own, even if at this stage of our knowledge we cannot give them an anatomical location or a neurophysiological interpretation. They may be considered the very inhabitants of inner reality. The two most important ones in the preschool age, and the only two that we shall describe, are the image of mother and the self-image.

Before proceeding we must warn the reader about a confusion that may result from the two different meanings given to the word *image* in psychological and psychiatric literature. The word *image* is often used, as we did earlier in this section, in reference to the simple sensorial images that tend to reproduce perceptions. With this term we shall now refer also to those much higher psychological constructs or inner objects that represent whatever is connected with a person. For instance, in this more elaborate sense, the image of the mother would mean a conglomeration of what the child feels and knows about her; even more specifically, the result of the *structure* that he gives to what he feels and knows about her. Although each child creates structures and patterns in a selective, individual way, certain

similarities occur in the structures of all children because of the similarities of the biological endowment and of the interpersonal situations.

In normal circumstances the mother as an inner object will consist of a group of agreeable images: as the giver, the helper, the assuager of hunger, thirst, cold, loneliness, immobility, and any other discomfort. She becomes the prototype of the good inner object. At the same time she will become the representative of the "Thou," the other human being without which, to follow again Buber, there would be no "I." There is no I without Thou. The mother becomes the most important Thou, but also the prototype of any other Thou, any other fellow human being who, in his essential human qualities, will be modeled after her. If a state of communion is established, the I and the Thou do not lose their individuality in the act of being together. Their being together adds, does not subtract. The negative characteristics of mother play a secondary role that loses significance in the context of the good inner object, the good Thou.

Much more difficult to describe in early childhood is the self-image. This construct will be easier to understand in later

developmental stages. At the sensorimotor level, the primordial self probably consisted of a bundle of relatively simple relations between feelings, kinesthetic sensations, perceptions, motor activity, and a partial integration of these elements. At the image level the child who is raised in normal circumstances learns to experience himself not exclusively as a cluster of feelings and of self-initiated movements, but also as a body image and as an entity having many kinds of relations with other images, especially those of the parents. Inasmuch as the child cannot see his own face, his own visual image will be faceless—as, indeed, he will tend to see himself in dreams throughout his life. He wishes, however, to be in appearance, gestures, and actions like people toward whom he has a pleasant emotional attitude or by whom he feels protected and gratified. The wish tends to be experienced as reality, and he believes that he is or is about to become like the others or as powerful as the others. Because of the reality value of wishes and images, there results what psychoanalytic literature has called a feeling of omnipotence.

In the subsequent endoceptual and paleologic stages the self-image will acquire many more elements. However, these elements will continue to be integrated so that the self-image will continue to be

experienced as a unity, as an entity separate from the rest of the world. The psychological life of the child will no longer be limited to acting and experiencing, but will include also observing oneself and having an image of oneself.

In a large part of psychological and psychiatric literature a confusion exists between the concepts of self and of self-image. In this section we shall focus on the study of the self-image. Also in a large part of psychiatric literature the self and the consequent self-image are conceived predominantly in a passive role. For instance, Sullivan has indicated that the preconceptual and first conceptual appraisals of the self are determined by the relationships of the child with the significant adults. Sullivan (1953a) considers the self (and self-image) as consisting of reflected appraisals from the significant adults: the child would see himself and feel about himself as his parents, especially the mother, see him and feel about him. What is not taken into account in this conception is the fact that the self is not merely a passive reflection. The mechanism of the formation of the self cannot be compared to the function of a mirror. If we want to use the metaphor of the mirror, we must specify that we mean an activated mirror that adds to the reflected images its own distortions, especially

those distortions that at an early age are caused by primary cognition. The child does not merely respond to the environment. He integrates experiences and transforms them into inner reality, into increasingly complicated structures. He is indeed in a position to participate in the formation of his own self. His own self acquires a structure.

The self-image may be conceived as consisting of three parts: *body image, self-identity,* and *self-esteem.* The body image consists of the internalized visual, kinesthetic, tactile, and other sensations and perceptions connected with one's body. The body and also the actions of the body on the not-self are discovered by degrees. The body image eventually will be connected with belonging to one of the two genders. Self-identity, called also personal identity or ego-identity, depends on the discovery of oneself not only as continuous and as same, but also as having certain definite characteristics and a role in the group to which the person belongs.

Self-esteem depends on the child's ability to do what he has the urge to do, but is also connected with his capacity to avoid doing what the parents do not want him to do. Later it is connected also with his capacity to do what his parents want him to do. His behavior is

explicitly or by implication classified by the adults as bad or good. Self-identity and self-esteem seem thus to be related, as Sullivan has emphasized, to the evaluation that the child receives from the significant adults. However, again, this self-evaluation is not an exact reproduction of the one made by the adults. The child is impressed more by the appraisals that hurt him the most or please him the most. These partial salient appraisals and the ways they are integrated with other elements will make up the self-image.

Before concluding this section I must mention that a large part of the psychiatric literature of psychodynamic orientation has made the error of seeing not only the child but also the adolescent and young adult as completely molded by circumstances, a passive agent at the mercy of others, either parents or society. Although these environmental forces are of crucial importance, we should not forget other factors. The person, even at a young age, is not a *tabula rasa,* or a sponge which absorbs whatever is given him, without he himself adding an element of individuality and creativity to what he receives and thus contributing to his own transformation. As we shall see in several parts of this book, the individual will never reproduce the experiences of childhood as an historian would; he always transforms

and recreates, in favorable or unfavorable ways. Some of the authors who study the effect of the family and of the environment on the future patient do so in a crude way, as if they were describing a rapport of simple linear causality. It would be like studying the intake of food but not the functions of the digestive system and the metabolic processes of the body. The following sections of this chapter, as well as Chapters 6, 7, and 8, will show how much more complex the unfolding of psychopathology can be.

VI
Psychodynamic Development in the Early Childhood of Schizophrenics

The child who is being raised in the family environment that we have described in the third section of this chapter often tends to participate as little as possible in the unpleasant reality. He tends to be by himself, and thus aloofness favors an overdevelopment of fantasy or life of images. On account of the negative characteristics of the environment, few are the images that have pleasant connections and that induce the child to search the corresponding external objects. The result is that inner life in these children is mainly disagreeable at this

level of development. Images become associated with others and spread an unpleasant affective tonality to all inner objects.

We may state that in these children an unbalance exists between external and internal psychological processes. The child escapes from the external life and lives preponderantly in his inner life, but the inner life is not pleasant either. A certain number of children perhaps succeed in escaping this dilemma, and eventually in escaping psychosis, too, by reverting to the antecedent sensorimotor level of development. They become hyperkinetic. They indulge in actions, even if not very coordinated or goal-directed, rather than in inner life. For reasons that still remain to be determined, only a minority of children can avail themselves of this defense. Moreover, it could be, as we have already mentioned, that these hyperkinetic children had undergone minimal brain damage at birth and that the psychological factors only accentuated the pathology.

The most important inner object at this age is the image of the mother or of the mother-substitute. The inner object of the mother is not a photographic representation of the real mother, but a transformation of it in accordance with primary process cognition. We

have seen that in normal circumstances, or even when the disturbance was only of moderate intensity, the child tends to build a positive or benevolent image of the mother. The future schizophrenic, however, does not build this benevolent maternal image in early childhood. He finds himself having to relate to a mother who, because of her perfectionism, excessive anxiety, or hostility, exposes him to overwhelming scolding, criticism, and nagging. At other times a detached attitude makes the mother appear remote, inaccessible, ungiving, perhaps inimical. Even though the mother may have positive characteristics and may even love the child and try her best, the future patient becomes particularly sensitized to one or all of four fundamental negative characteristics: anxiety, hostility, detachment, unpredictability. The child becomes particularly aware of these negative characteristics because they are the parts of mother that hurt and to which he responds deeply. He ignores the others. His use of primary process cognition makes possible and perpetuates this partial awareness, this original part-object relationship, if we use Klein's terminology. The patient who responds mainly to the negative parts of mother will make a whole image of mother out of these negative parts, and the resulting whole will be a monstrous transformation of mother.

Thus the image of mother as an inner structure is radically different from that built by the child raised in normal circumstances. Later this negative image may attract other negative aspects of the other members of the family or of the family constellation as a whole, so that the mother image will be intensified in her negative aspect. Mother becomes the malevolent mother of the psychiatric literature, and her image becomes the malevolent image: an inner structure that, in a latent or unconscious way, may persist for the lifetime of the patient.

If, at this time, the child could possess the vocabulary of the adult, he would call the mother barbarous, bitter, bloodthirsty, brutal, callous, cold-blooded, cruel, demonic, devilish, diabolical, envious, evil-minded, faithless, false, ferocious, hardhearted, harsh, hateful, hellish, ill-disposed, ill-natured, implacable, infernal, inhuman, maleficent, malicious, malignant, maligning, merciless, relentless, revengeful, ruthless, Satanic, sinister, stony, unfeeling, unkind, and so forth. These names, which I put in alphabetical order, actually have been used by several adult patients at a certain stage of psychotherapy to describe their parents, generally the mother. The mother image, as the representative of the other—that is, of any other human being and of the interpersonal world—becomes a negative Thou. A normal I-Thou

relationship, in Buber's sense, cannot exist. The child will have difficulty in accepting the others, whom he models after the mother. The Thou is too threatening and is a carrier of too much anxiety. This is the beginning of the schizophrenic cleavage, this never complete acceptance and integration of the Thou, of that part of the self that originates from others. Unless deprived of its emotional import or potentiality, this Thou tends to remain unintegrated or to become dissociated, like a foregin body that is easily externalized later in life in forms of projections and hallucinations.

This vision of mother is somewhat understood by the mother, who responds to the child with more anxiety. The mother expresses her anxiety in the form of hostility toward the child, who, in his turn, will be even more adversely affected. He will respond with behavior that will be more objectionable to the parent. Furthermore, the mother most of the time feels guilty for her hostility, and this guilt feeling increases her anxiety. A circular process of ominous proportions originates, which produces intense distortions and maladaptations.

In the case of girls, a typically Freudian Oedipal situation may facilitate the development of the bad image of the mother. A rivalry

with the mother for father's love may help the future patient to see mother in a bad light. In the cases in which the malevolent image of mother is formed, two tendencies may develop. The first is an attempt to repress from consciousness the reality of the mother-patient relation, but, as we shall see shortly, this task cannot be easily achieved. The second tendency is to displace or project to some parts of the external world this type of relation.

Rosen (1962, 1963) uses the concept of "early maternal environment" to explain the whole psychodynamics of the schizophrenic psychosis and, later, the characteristics of the psychotic symptomatology. For Rosen, whatever impinges upon the child is experienced as related to mother. Whatever has to do with mother, according to Rosen, gives special shape to the appreciation of the world. Rosen seems to believe in the reality of the intense perverse motherhood of the patient's mother. He does not seem to be aware of the transformation and intensification of her negative traits that we have described in this section. In other words, Rosen accepts the experiential mother as the real mother, just as the patient does.[7] When patients in psychoanalytically oriented therapy lose the overt paranoid symptomatology and discuss at length their mother, they

tend to reexperience her as they did during the first psychodynamic period studied in this chapter; and many therapists have accepted their patients' version of facts.

In the majority of cases the inner object of the father consists also of negative, although less intense, characteristics. The future schizophrenic feels that both parents, in different ways or in similar ways, have failed him. In a minority of cases the parental roles are inversed, and what we have described in reference to the maternal image pertains to the paternal and vice versa. At this stage of our knowledge we cannot positively state why future schizophrenics develop this negative, malevolent image of the mother. We have seen that in only approximately 25 percent of the cases does this inner image correspond to the real mother. Why are 75 percent of schizophrenics transforming the image into a much worse one? We can postulate only hypotheses. Further studies are necessary. Time factors and cyclical recurrences have to be considered. For instance, each child has to be disapproved and criticized at times, but the good mother will permit the child to recuperate between one punishment or criticism and another and will not cause too strong or too frequent psychological unpleasure. No matter how critical, the average mother

will not inflict on the child an inner feeling of worthlessness. Similarly, the average mother in some cases may not be able to prevent herself from preferring children other than the patient, or may not be able to abstain from making promises she will never keep. Nevertheless, she is able to give to the child the feeling that he too counts and is never forgotten. Myriads of intangible little factors are already operating early in life, and the scientifically minded researcher who would like to calculate the algebraic sum of them and determine whether the result is positive or negative is doomed to be frustrated.

It could also be that because of biological predispostion to be taken into consideration later in this chapter and also in Part Six of this book, the future schizophrenic experiences much more intensely a phenomenon that occurs in every living animal organism. Inasmuch as painful characteristics or negative parts of complex stimuli generally hinder adaptation, they are more dangerous from the point of view of survival; thus evolution has favored a stronger response to them. We react more vigorously to pain than to pleasure, and to sorrow more than to joy. This stronger response to the negative may involve also the early interpersonal relations, especially in the future schizophrenic.

The difficulties in accepting and integrating the Thou are manifested by the reluctance of children raised in a disturbed environment to acquire the language and ways of the surrounding adults and by the emergence of autistic ways and expressions such as neologisms. Autistic tendencies exist even in normal children to a minimum degree, but they are more pronounced in pathological conditions, generally when the child is afraid of the first interpersonal relations. Unless the child develops child schizophrenia, these autistic tendencies are outgrown, and the individual acquires the use of verbal symbols learned from others. However, a propensity to lose the symbols of the others and to return to one's private autistic ways will persist.

We must take into consideration now the other important inner object—the self-image. The future patient, raised in the circumstances that we have described in the third section of this chapter, tends to see himself, not in the way he appears to others or as the parents have appraised him, but in a much worse condition. We can repeat here what we have said about the mother image. The child does not respond equally to all appraisals and roles attributed to him. Those elements that hurt him more stand out as salient elements and are

integrated disproportionately. The self-image thus, although related to the external appraisals, is not a reproduction of them, but a caricature of them. The grotesque representation of the self that future patients already form at this early age would stupefy their parents if they were aware of it. According to my own observations, it would stupefy approximately 80 percent of them, who never consciously or unconsciously wanted to inflict it on the children. It may remain as an inner structure, which, in a latent or unconscious way, may persist for the lifetime of the patient.

The body image does not generally correspond to the actual physical appearance. The child may perceive himself as little, feeble, helpless, and distorted. As many authors have described, quite often the preschizophrenic child has also some indecision as to what his sex is going to be.

Some uncertainty about sexual life exists in normal children, too, even in children older than those studied in this chapter. This frequent uncertainty has various causes. First of all, our cultural mores make difficult any frank conversation about sex between parents and children. Consequently many children who have no access to other

sources of information will retain a distorted or fragmentary knowledge of sexual life. Secondly, it is difficult to explain “the facts of life” in a simple language that young children would understand. Thirdly, the parents feel with some justification that it is difficult to talk about sexual matters without arousing some feelings that cannot be satisfied. In children who tend to become schizophrenic in adult life, the uncertainty about sexuality is of a different nature. It concerns the sex and gender identity. Some of these children do not know what their sex is going to be. Although they know that they are boys or girls, they are not sure that they will maintain their sex throughout their lives. Boys may lose a penis; girls may grow one. Although even normal children or children who later develop less serious psychiatric conditions occasionally have these thoughts, in the preschizophrenic they assume the form of serious and disturbing doubts. In many cases the doubts are related to the fact that children somehow connect a sense of hostility coming from others with their belonging to a given sex. If they were girls instead of boys, or boys instead of girls, they think their parents would be more pleased with them. If the most disturbing parent is of the opposite sex, the child would like to be of the same sex as this parent, so that he could resist him or her better.

In my opinion, the most common cause of sexual or gender uncertainty is the fact that the child who feels rejected by both parents tends also to reject both parents and therefore has difficulties in identifying with either one of them. I have not found fear of castration to be an important or frequent cause of the anxiety that leads to schizophrenia. Even the most orthodox Freudian analysts have found that the early psychic traumata in cases of schizophrenia are not related to the Oedipus complex. However, in families or cultural environments where sex is strongly expressed or repressed, the Oedipal situation may in certain cases increase the already existing anxiety and make the occurrence of schizophrenia more probable. The child attributes his sexual desires to his being bad.

A combination that I have found in some preschizophrenic girls is the following. Since early childhood, the girl has felt rejected by the mother, who, in rejecting her, rejected herself. The same mother had a different attitude toward "her boys." Later, the girl was afraid of closeness to the father because of her incestuous strivings. She rejected the father or managed to be rejected by the father in order to escape her sexual desires. In this situation, too, the preexisting relation with the mother is the most important factor, and has sensitized the

girl to such a degree that she is not able to cope with her incestuous feelings.

Self-identity and self-esteem in the age period that we are considering are difficult to study. Future schizophrenics at this age do not see themselves as occupying a definite role within the family. They perceive themselves as being unliked and unwanted. Some of these children have a definite feeling of being bad, but others are not even sure of being bad, because they may change and improve. Paradoxically, they would feel less insecure if they could see themselves consistently bad, without any uncertainty about their role or image.

Guilt and feelings of worthlessness may already be very pronounced in the preschool age. They are generally attributed to parental authority, and in classic psychoanalysis are considered expressions of a harsh, tyrannical superego. The following mechanism often occurs. The child nourished some hostility for the parent, but he could not accept this hostility, and he projected it to the parent. Thus the parent was endowed not only with his own hostility, but also with the child's hostility and appeared doubly harsh and punitive. By

introjecting this primitive attitude the child developed a strong sense of guilt and increased the “badness” of his own image.

Even normal children occasionally have the feeling that adults know their thoughts or steal their thoughts (Erikson, 1940; Kasanin, 1945; Piaget, 1948). In the preschizophrenic child this impression is enhanced by the fear that the parents may know the feelings of hostility he harbors for them and by the anticipation of consequent punishment. Other aspects of cognitive immaturity, which are easily outgrown in normal children raised in normal circumstances, complicate the picture. Adualism, or inability to distinguish inner from external reality, is retained longer than usual. Inasmuch as life of images in these children is predominantly unpleasant, the result is a negative appraisal of the world. Whereas the normally raised child learns to take things for granted and acquires fundamental optimism and basic trust, children described in this section live in a state of ominous expectancy. They will experience what Laing (1960) has called ontological insecurity. Later these children will be more and more under the impression that whatever occurs is brought about by the will of those unpleasant clusters of images that represent the parents, especially the mother.

VII
The Building of Early Defenses

The child that we have described is in a very distressful situation. Parents are experienced as grotesque inner images or are paleologically transformed into terrifying fantasy figures. The self is also seen as a deformed, grotesque, worthless creature, or as a presumably bad person.

What we have just expressed is a translation into adult language of what a child age 2, 3, or 4 experiences. Actually he does not have the vocabulary necessary for expressing these feelings and emerging ideas. He often mediates these experiences through endocepts (or preverbal structures). This possibility is beneficial because endocepts are not representations and are not generally acutely traumatic. However, the child must resort to other defenses. The inner objects are very painful, and he cannot bear them. If these inner constructs were allowed to become connected with an increasing number of ramifications and implications, they would increase their potentiality and would devastate the psychological life of the child. This is probably what happens in childhood schizophrenia (see Chapter 44). One of the major defenses consists in separating from consciousness

(or dissociating) the emotional impact of these constructs. A massive repression ensues. In the majority of cases the child who has at first to contend with the image of the malevolent mother succeeds in repressing it from consciousness. At a conscious level he succeeds in transforming the malevolent Thou into a *distressing* Thou. The Thou is still distressing, but it has lost the power to demolish the patient to an enormous degree.

In order to understand better what occurs in the transformation of the maternal image in the preschizophrenic, we must stress that different transformations occur in cases where less serious pathology is involved. In conditions that lead to psychoneuroses, or character disorders, the child who suffers on account of his relations with the rejecting parent, generally the mother, tries desperately to preserve a good image of the parent, and he often succeeds, at times to a very pronounced degree. He wants to feel that the parent is good.[8] If mother is punitive and anxiety arousing, it is not because she is bad but because he, the child, is bad—mother is right in being harsh and strict with him and showing how bad he is. The child who is raised in this environment and wants to maintain the image of the mother as a benevolent person tends therefore to accept her negative appraisal of

him. By accepting this negative appraisal, he develops the self-image of the bad child, that is, he considers himself inadequate and bad, and has little self-esteem.

The preservation of the good image of the parent is made possible by the removal from consciousness of the most unpleasant traits of the parent. Thus, the child will have two images of the parent: the good image, which is conscious, and the bad image, which will remain unconscious. The good parental image appears in myths, legends, and dreams as God, the fairy, the magic helper, the protector. The parental bad image appears as the witch, the stepmother, the bad man, and so forth.

Why does the child need to preserve the image of the good parent? In early childhood the parent, generally the mother, is the person who connects the child with the environment; she is the Thou, the representative of the interpersonal world. The child must accept her in order to fulfill his inborn potentialities for full maturation and socialization. If she is not good, his need and desire to accept the world will be thwarted, and certain tendencies toward autism and arrested socialization will manifest themselves. In the cases in which the

mother is not the almost exclusively important adult, this need to preserve her good image is not so strong.

There are other reasons for wanting to preserve the image of the good parent. It is more tolerable for the child to think that he is punished by the good parent because he deserves to be punished than to think that he is unfairly punished. If he is punished although he is not bad, he will have a feeling of despair; the situation will seem to him beyond remedy, hopeless. Maybe he is so horrible and worthless that he must be punished even without being bad. Some children actually force themselves to do “bad things” in order to be bad because they want to be punished for something that they have done rather than for nothing. By being “bad” they preserve the self-image of the bad child. In addition, if mother is good, the child thinks that she will love him even if he is bad.

In the majority of the cases where schizophrenia will eventually occur, the transformation of the parental image into a benevolent one does not take place. At a conscious level the Thou remains distressing, although not malevolent. The child, however, retains hostile feelings for the parents. Moreover, the characteristics of the internalized

parents are generalized to some extent to all women or to all adults.

The "I," that is, the self-image, is also altered. The negative attributes of the self are to a large extent repressed. Also, the child no longer sees himself as hated, falsely accused, or the target of hostility. He continues, however, to see himself as weak. The "bad" me is transformed into the "weak" me. The child will see himself as a weakling in a world of strong and distressing adults.

In a minority of cases of schizophrenia the child is able to retain the good maternal image that he built before the end of the second year of life, when the mother could still relate to him with care and some devotion. In these cases the child tends to continue to act like a baby or to manifest strong regressive tendencies toward babyhood. He learns to remain a dependent person. If he is still a baby, if he is completely taken care of and has no will of his own, mother will be good to him. Mother then will appear again not only as good, but also as omnipotent, and the child will tend to maintain a parasitic attitude. Any real or symbolic separation from mother is capable of producing great anxiety even much later in life. I have found these tendencies to a more or less pronounced degree in several preschizophrenics and

schizophrenics, but in my experience they are not the most common or the usually predominant trends in the psychodynamics of schizophrenia.

Notes

[1] Some readers may wonder why we call this factor presumably necessary and not just necessary. The reason is two-fold: (1) statistical evidence is very suggestive of causal connections, but the number of cases seriously studied is a minority of all cases of schizophrenia, and (2) because we cannot give a statistically convincing empirical proof, we would like to give a logical explanation of how the psychodynamic conflict leads to the disorder. Again this explanation, given in Chapters 7 and 8, is convincing and presumably correct, but it still contains gaps in strict logic that leave it open to criticism.

[2] I actually would be more inclined to say that only 20 percent correspond to this image, but I have included doubtful cases and conceded a maximum of 25 percent.

[3] For the preparation of this section, I had to draw liberally from previous writings (Arieti, 1957a, 1965c, 1967, 1971a).

[4] Precursors of communion existed also in the sensori-motor period, and are generally called symbiosis or parasitism. These terms indicate one aspect of the contact or the extreme dependency. Communion implies the possibility of sharing the joy of being together.

[5] Buber's I-Thou expression corresponds approximately to Sullivan's me-you expression.

[6] For a more elaborate analysis of images, endocepts, and paleologic thinking, see The Intrapsychic Self (Arieti, 1967).

[7] Lidz (1969) is not less definite than Rosen in characterizing the mother of the schizophrenic. Lidz speaks of the "engulfing parent, who arouses homicidal impulses or provokes incestuous fears."

[8] The tendency to preserve the “lovableness” of mother and the consequences of such tendency have been considered by Suttie (1952) in a different frame of reference.

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