INTERPRETATION OF SCHIZOPHRENIA

Syndromes Related to Schizophrenia

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We have seen throughout this book that the scope of schizophrenia is large indeed, but it becomes much larger if we add to it the psychiatric conditions that various authors have included in a less definite conception of the disorder. This tendency to enlarge the scope of schizophrenia started with Bleuler (see Chapter 2); but it has been pursued since then by several authors. Some inclusions did not prove to be justified by the test of time. However, the three syndromes that we shall briefly illustrate in this chapter (paranoia, anorexia nervosa, and childhood schizophrenia) are probably related to schizophrenia.

I
Paranoia

In some psychiatric centers today the diagnosis of paranoia is never made; it is replaced by such classifications as the paranoid type of schizophrenia, paranoid state, and paranoid condition. Kraepelin, who was the first to give the diagnostic criteria for paranoia, divided all paranoiac-paranoid syndromes into three groups. At one extreme he put the paranoid type of dementia praecox (schizophrenia). This

type includes cases that present projective and delusional symptoms together with the other regressive symptoms of schizophrenia. At the other extreme he put cases of paranoia, a syndrome characterized by well-systematized delusions, with no tendencies toward regression, remission, or recovery. Hallucinations, according to Kraepelin, may occur in paranoia, but only rarely; regression may be present also, but only to a minimal degree.

Between these two groups Kraepelin put the paraphrenias, which in American psychiatry correspond roughly to "paranoid states" or "paranoid conditions." Paranoid states are supposed to be delusional syndromes that are fairly well systematized but are not as logically constructed as paranoia. The differential diagnosis between paranoid conditions or states and the paranoid type of schizophrenia is often determined more by the diagnostic orientation of the psychiatrist than by the actual symptomatology.

The confusion between these terms is even more pronounced when adjectives and personal nouns are used. A person suffering from pure paranoia is a paranoi**ac**, and not a paranoi**d**, as he is occasionally called. A paranoid is a person suffering from a paranoid state or from

the paranoid type of schizophrenia, not from paranoia. Just as we call a person suffering from schizophrenia, a schizophrenic, and not a schizophrenid, so we must call a person suffering from paranoia a paranoiac. Paranoid means "not quite paranoiac but similar to, or almost, a paranoiac."

Many authors (for instance, Kolb, 1968), however, put paranoid conditions and paranoia together, either because they believe that the two conditions cannot be distinguished or because paranoia or "pure paranoia" or "true paranoia" is such a rare condition that it does not deserve a separate consideration. Most authors who reluctantly recognize the existence of paranoia as a separate entity consider it a very rare disease. Paranoia is said to be much more frequent in the male sex, especially after the age of 35-40. Adolph Meyer described the prepsychotic personality of the paranoiac as characterized by rigidity, pride, haughtiness, suspiciousness or actual distrust, and disdain. A large percentage of these patients are unmarried and show little interest in sexual life; the few paranoiacs who get married are unable to establish a warm conjugal relationship. Some patients disclose indications of overt or latent homosexuality. Contrary to early psychoanalytic formulations, however, homosexuality does not seem a

prerequisite for paranoia.

I feel that it is useful to retain this condition as a separate clinical entity, even if we do not understand it completely and do not know how close it is to schizophrenia. We are probably correct to exclude from this group all cases presenting hallucinations and obvious signs of regression. Even if such cases are omitted, however, paranoia is much more common than is usually believed. The diagnosis of paranoia is seldom made for several reasons:

1. Many psychiatrists are still influenced by the early descriptions of this disorder, which portrayed only its most severe forms. They adhered to Kraepelin's view that no remission or recovery was possible. Contrary to general belief, however, the majority of cases are mild.

2. Many cases are not recognized and never reach the office of a psychiatrist. The patient has no insight into his condition, and people take him for an eccentric, fanatic, or strongly opinionated person, but not necessarily a psychotic.

3. Some paranoiacs eventually act out and are occasionally labeled as psychopaths. Actual paranoiac-psychopathic mixtures do occur. In my own clinical experience I have encountered quite a few of them, which I cannot report

> here because they would be easily identified. Although I cannot be absolutely sure about this point, my clinical inferences when I read the life history of some historical figures like Hitler and Stalin lead me to believe that they were at first complex psychopaths, with an underlying psychotic structure that eventually revealed itself (Arieti, 1963c). Some psychopathic-paranoiacs, endowed by intelligence, fluency of speech, and apparent strength of personality, find followers and satellites as easily as they find persecutors—two groups of people who are useful in enhancing the power drive.

The notion that mild paranoia is a common disease is gaining recognition. Revitch (1954) made a study of conjugal paranoia and reported four cases in detail. In this type of paranoia delusions and pathological attitudes are directed against the spouse. The pathological attitudes characterized by humiliating and destructive acts against the marital partner may precede by many years the outbreak of obvious delusions. The patient always preserves good contact with the environment, is able to conduct his affairs, and may be able to veil projections so skillfully that, not the patient, but the spouse may be considered abnormal and may become the target of indignation of the patient's immediate family. According to Revitch,

homosexual conflicts and a general feeling of inadequacy aggravated by conjugal relationship are the most important factors in the genesis of conjugal paranoia. Revitch added that projective techniques do not always elicit the gravity of the clinical condition but are valuable in the evaluation of the personality structure of the patient. The best diagnostic tool, however, is an unhurried and careful interview of both spouses by the same psychiatrist. The problem of disposition is also extremely difficult, defying simple solutions, on account of the apparent lucidity and productive capacity of the patient.

Johanson (1964) reported her study of fifty-two cases of patients suffering from mild paranoia. She did her study in Uppsala and all but seven of her patients were Swedish. Of the seven foreign-born patients, three were refugees. Johanson's patients did not differ from the average population in intelligence or marital status. Twenty-seven were men and twenty-five women. Only six of them, all male, were eventually diagnosed as schizophrenic.

Psychodynamics

Difficulties with one's parents and other family situations similar

to those described in Part Two in reference to schizophrenic patients are found also in the life history of paranoiacs.

The future paranoiac keeps a “chip on the shoulder” and harbors a secret desire for revenge against the oppressor. Like the schizophrenic, he generally shifts his hatred from the people who made his life uncomfortable and painful to imaginary oppressors. Endowed with superior intelligence he spends an enormously long time brooding and conceiving plans of revenge.

My clinical experiences have not revealed that homosexual leanings are important in the psychodynamics of most paranoiacs. What is prominent, however, is either a confusion in sexual identification or a sense of deep inadequacy in sexual life. The inadequacy actually manifests itself in all areas of interpersonal relations. The patient is almost compelled to live alone, aloof, in celibacy, and is indeed considered inadequate or bizarre. But he cannot accept this fate and lives for the time when he can manifest to the world his real worth. That time never comes; he feels more and more disappointed, to the point of desperation. Eventually a life experience occurs that he was consciously or unconsciously waiting

for. He gives special meaning to the episode: this may be the beginning of an ever-expanding paranoiac system.

Among the events that paranoiacs have misinterpreted and used as the beginning of a delusional system I have found with great frequency the following four:

1. The patient is involved in an automobile or other accident. He starts to believe that the accident was not casual but planned, and he eventually discovers the machinery of a conspiracy behind it. If the patient was the only one to survive in the accident, or hardly escaped death, he may give to the episode a mystical resonance. He may consider himself destined to save the world.

2. The patient was really the victim of an injustice or, more frequently, of an error. For instance, he was unjustifiably accused of stealing. Subsequently he builds up a system of delusions springing from the episode. An important variation of this second possibility is the following: the patient has not been accused, but he believes he has been accused. For instance, some people seem to him to indicate that he is the one suspected of having committed a particular crime that was reported in the newspapers.

3. The patient interprets an attitude or action of a person close to him (generally the spouse or fiancee) in a peculiar way and subsequently elaborates a paranoiac system over the episode.

4. The patient has undergone a permanent change, for instance, facial plastic surgery or sterilization. Although he himself chose to be operated upon, he is not satisfied with the result and attributes evil intention to the surgeon or to any person who recommended the operation. Other changes affecting position, location, and so forth, may also act as precipitating events. This fourth type of possibility is more frequent in paranoid schizophrenia than in paranoia.

An important point to be considered is the relevance of the original episode. It is not just a precipitating event; it is a very important dynamic factor, without which the patient would have been able to check, or even compensate, his psychotic propensity.

Tolentino (1957a, *b)* reported the interesting diary of a patient who developed true paranoia after he felt that people were accusing him of having stolen a carpet. Actually nobody accused the patient, but he interpreted the words and gestures of some people in a way that sustained his convictions. The patient became sure that a colonel in

the army was accusing him when actually the colonel himself was the thief. Thus he reported the colonel to the proper authorities. This action led to suit for slander, which was followed by incarceration and eventually hospitalization of the patient. In the hospital the paranoiac attitude of the patient extended to attendants and nurses, who retaliated by isolating and restricting the patient in a cruel manner. The patient's diary is reminiscent of a Kafka novel. Tolentino interpreted the case as a case of true paranoia. According to him the delusional idea was the projective reconstruction of a deep feeling of guilt. The external events, that is, the theft that really happened and the possibility that the patient would be accused, motivated and deformed the feeling of guilt. According to Tolentino the unconscious self-accusation of the patient was externalized in the following way:

1. Projection (by accusing the colonel of theft).

2. Self-punishment (with actions that led the patient to incarceration, hospitalization, and bad treatment from attendants).

3. Regression to primary narcissism. The patient at the acme of the illness could not concentrate on, or be concerned with, anything else—only his delusional system.

In the third case that we have listed (when the patient interprets in a peculiar way an attitude or action of a person close to him) it is not accurate to dismiss the point of view of the patient as merely delusional or referential. I have become convinced, and Revitch has also, that the other person (generally the spouse) is often psychologically disturbed, although not psychotic, and is given to conscious or unconscious actions that increase the vulnerability of the patient. Thus in conjugal paranoia a particular family relation explains to some degree the psychodynamics of the disorder or its perpetuation. However, it does not entirely explain its origin and the selection of the particular cognitive mechanisms necessary to sustain the delusions.

Formal Mechanisms

Once an idea becomes dominant in the mind of a paranoiac, for example, the thought that he must avenge a misdeed or uncover and openly condemn his own persecutions, he needs to demonstrate that the idea has a basis in fact. He has to transform his beliefs into certitude, in spite of what appears to others to be a lack of corroborating evidence.

I have accumulated some presumptive (but not unquestionable) clinical evidence that some psychopaths who later revealed themselves to be (or become) paranoiacs at first were aware that they were lying. Later they accepted their ideas as true in order to sustain their motivation. One is again reminded of Hitler, who at first recognized he was lying. He is the one who said that the bigger the lie, the more easily it will be believed. Later there is presumptive evidence that he too came to believe his own lies, which thus became delusions (Arieti, 1963c).

The paranoiac does not resort to obvious regressive phenomena in order to demonstrate to himself and to others that what he believes is true. He does not experience the psychotic insight of the paranoid schizophrenic, that sudden illumination resulting from the acceptance of paleologic forms. The paranoiac starts by accepting some premises as undeniable truths. These truths, however, have to be defended by uncovering hidden connections and by discovering a plan, a plot, or a structure that was not apparent. The patient becomes engaged in collecting material that will prove his allegations. He indulges in prolonged and elaborate investigations, and little by little he connects things to create a well-structured system, which actually consists of

misinterpretations and distortions.

These distortions are so well rationalized as to give the impression to the layman, and occasionally even to the psychiatrist, that the patient is perfectly sane. As a matter of fact, he appears to be a very intelligent person who has been able to find relations between things and facts that seemed unrelated to more naive people.

How does the patient find these relations? As already mentioned, he does not resort to paleologic thinking, or to a confusion between identity and similarity. Unlike the schizophrenic, he follows only secondary process mechanisms. In scanning the several possibilities that may account for a certain fact, he selects and accepts as true the ones that fit his overall system or his preconceived belief. He can view clues and possibilities as sure evidence, so that what should remain a hypothesis becomes a fact if it fits the preconceived notion. In this way the unconscious wish and the impelling need to believe become supported by a cognitive scheme.

To give an example, the patient happens to see X., his alleged persecutor, in the street where he himself works, and he concludes

that X. has come to spy on him or to harm him. The fact that X. is there becomes a proof that X. is persecuting him, whereas it should be only a hypothetical possibility, soon to be discarded. Similar clues, of course, are studied by the police in evaluating suspects and are discarded unless supported by other facts. The scientist too conceives hypotheses and wants to determine whether they are valid or not. But for the paranoiac the possibility becomes certainty because it is "proved" retrospectively by what it purports to prove. That is, because X. is a persecutor and wants to molest the patient, his being on the street where the patient works is not coincidental but is caused by the fact that X. is there to persecute the patient. Because X. is there to persecute the patient, it is true that X. persecutes the patient. This is circular reasoning, and obviously, incorrect; but it is not paleologic.

Such paranoiac thinking, based on premises supported by secondary process mechanisms, is occasionally also found in paranoid conditions and in the paranoid type of schizophrenia, where it is mixed in with paleologic thinking and other regressive types of cognition. In my opinion, the diagnosis of paranoia is justified only when there are no traces of paleologic or other regressive types of thinking.

The paranoiac system becomes the only inner object the patient cares about. Any therapeutic attempt would have to aim at reenlarging his attachment to other inner objects. This is a difficult task because relations with the other objects increase his anxiety and enhance his desire to withdraw again into his paranoiac construction, within which he has become a very efficient manipulator. Although the most typical conditions of paranoia are chronic and progressive, many cases are characterized by episodes that alternate with periods of normal or almost normal behavior. In some instances, the delusional symptoms disappear and are replaced by hypochondriacal or even psychosomatic complaints.

The following case report is typical of the common form of mild paranoia.

Mr. Paruval

Mr. Paruval came for treatment at the age of 49. He stated that an old trouble—incomprehension with his wife—had become steady and persistent, and he wanted help. He seemed sincere and desirous of improving his marital situation. Soon it became evident that he had a

need to convince somebody of how much was wrong with his wife. A psychiatrist would be a person who would understand him.

The patient had emigrated ten years previously from Europe. He was the older of two siblings in a middle-class family. His father was a weak man, completely henpecked by his wife. The mother was described as a spendthrift, almost to the point of irrationality, and as oblivious to her maternal duties. The patient and his sister, when they were in their teens, advised the father to divorce the mother, but the father did not agree. He felt that for better or for worse he had to remain with his wife. Early life seemed uneventful to the patient. He did well in school and became a professional man.

In his early twenties he became interested in Alicia, a girl whom he seriously considered marrying. Paruval said that a year after he had started to date this girl, a good friend of the family revealed to him that Alicia was promiscuous and a woman with other undesirable habits. The friend gave Paruval ample evidence that these allegations were true. The patient decided to break the friendship, felt disappointed in women in general, and was not too optimistic about ever obtaining love. He had subsequently occasional and unimportant dates, but a few

years later he let himself be convinced by a matchmaker to marry Patricia, a girl who was represented to him as "immaculate," a nice girl from a good family; as a matter of fact, she was the sister of a clergyman. It is important to add that in the particular local European environment where the patient lived marriages arranged by matchmakers were not uncommon. The patient met Patricia, liked her, and decided to marry her. The date of the wedding was arranged a few months after the first meeting. About two months prior to the wedding day Patricia told her fiance that she preferred to wear a regular dress during the wedding ceremony, not a white bridal gown.

The patient was shocked by this remark. On the best day of one's life, why not wear the white gown, symbol of purity and innocence, as brides have traditionally done for thousands of years? He tried to convince Patricia to wear the white gown, and Patricia agreed. Nothing was said any more about this little incident, and the marriage took place as arranged. But on the wedding night, the patient, who is not a physician, submitted his wife to a regular gynecological examination. He felt that Patricia's hymen had a big opening and that her vagina was so large that it seemed to indicate that she had already given birth to a few children. He felt this was incontrovertible evidence that the

woman he had married was not a virgin. The matchmaker who had represented her as an immaculate girl was a cheater. Now Paruval could understand Patricia's reluctance to wear a white gown during the wedding ceremony. How could a woman who does not feel pure inside wear a symbol of purity?

During the wedding night Mr. Paruval became increasingly infuriated, beat the wife up, and in a vague way threatened more energetic actions. The wife vainly protested her innocence. Finally she suggested that she be examined by a physician, who would determine and testify whether she was a virgin or not. Two days later a doctor examined Patricia and certified that she was a virgin. This fact, however, did not reassure Paruval. He had evidence that this doctor had been a friend of Patricia's family for a long time and consequently would make statements only in her favor.

Although unconvinced, the patient "decided to forgive" his wife and even "allowed himself to have intercourse with her." During the treatment he repeatedly said that he forgot the incident that had occurred on the wedding night, but it was obvious that he not only did not forget it, but continued to brood about it and to exploit it in order

to give a special coloring to his relation with his wife. Soon a child was born, and Paruval never doubted that he was the father. However, some events that occurred later on were interpreted by him in such a way as to reinforce in him the image of his wife as a woman unworthy of wearing the bridal gown.

One of the principles in which the patient believed was that wives should not go to work; only husbands. Mrs. Paruval had promised not to work; however, Mr. Paruval would occasionally call his home during the day, and if nobody answered, he would think that his wife had gone to work in spite of her promise. He did not know what kind of work the wife was engaged in. He knew that the work she would do was reputable, but that did not matter. She had broken the promise not to work. He thought she was putting the earned money in banks and then hiding the bankbooks in secret places so that he had no idea of how much money she had saved or earned. He was also sure that Patricia was spying on him. He was convinced that she was opening all the mail he received although he had told her absolutely not to do so. What evidence did he have? He had noticed that a bottle of glue that was on a shelf in the kitchen was half empty. This was convincing proof that she steamed the envelopes of the letters when they arrived,

read the letters, glued the envelopes shut again, and put them back into the mailbox so that he would not be aware that the mail had been tampered with when he arrived from work.

His assumption became certainty when the wife told him that at Christmas she had given a five-dollar tip to the mailman. Why would she give such an enormous tip? They were not wealthy people. Obviously she had done so to keep the mailman silent or on her side because he had become aware of what she was doing to the mail.

The history of this case is too long to be reported in its entirety. There are many details that reveal how minor episodes were interpreted to support the atmosphere of lies and subterfuges that the patient imagined his wife was creating. On the other hand, it is possible to conceive that with her behavior the wife contributed to perpetuating her husband's doubts. As a matter of fact, further developments suggested that this was the case. With Paruval's permission I interviewed his wife a few times, and she repeated to me that all the accusations of the husband, from the wedding night to the present, were false, with one exception. She was indeed opening the letters that he was receiving from his family and regluing them again

before he arrived home from work. She was doing so because those letters were detailed accounts of all the difficulties the family had. The news in these letters was disturbing him very much and would prey on his mind. She wanted to be prepared and help him. I was indeed shocked when I heard this. It became obvious that the wife too was trapped in a paranoiac setup. Obviously she was cooperating in keeping alive a paranoiac structure.

Other circumstances were difficult to evaluate. The patient complained that the wife was cold and distant. He interpreted this attitude as proof that she could not be warm when at the same time she was involved in secret machinations. But how could the wife not be distant and cold when she felt constantly accused and under investigation?

There was in Mr. Paruval's attitude also a need *not* to arrive at the truth, a need to perpetuate the atmosphere of doubt and suspiciousness. None of his investigations were carried out as a prosecuting attorney would do. For instance, when it was decided that the wife be examined by a physician to prove whether she was a virgin, he did not object to the choice of a physician who was

immediately classified as a friend of the family. As a matter of fact, at that time the fact that the physician was a friend was welcome because the whole matter would be less embarrassing. Later on, the very same fact permitted the perpetuation of the doubt.

Mr. Paruval was very eloquent in his speech and at times quite convincing. He would talk with emphatic fervor and at other times the quasi-legalistic style that paranoiacs and paranoids have. He would say, “If my wife had told me she was not a virgin, if she had told me she wanted to go to work, if she had told me that she had had an irresistible impulse to open my mail, I would have tried to understand, to excuse, to forgive; but she did nothing of the sort: she lied.”

One could have expected that Mr. Paruval would not want to live with a person for whom he had no trust or respect, but on the contrary he claimed that he loved her very much and that he wanted to get to understand the incredible things that she was doing. He wanted to find out why she did such strange things and tried to hurt him so much. Obviously he had the need to perpetuate the paranoiac situation.

Treatment helped the condition to some extent, but much

paranoiac ideation remained. The paranoiac periods later alternated with periods characterized by hypochondriacal preoccupations.

Although the manifest illness probably started the day of the wedding, and there have been in the subsequent twenty-five years many exacerbations and remissions, there has been no regression or deterioration. On the contrary, since the onset of the illness the patient has been able to make considerable progress in his professional activities. When the political situation in Europe made him emigrate to the United States, he adjusted well to the new country, overcame external difficulties, and continued to make progress in his career. At the same time he felt inadequate, ineffective, overwhelmed by family problems, deserted, and alone. His tendency toward intellectualization and his work protected him from complete collapse. At the same time they favored in him a paranoiac structure in which he could channel his conflicts. We do not know much about his experience in childhood. We do know that, probably with justification, he never accepted his mother in his heart. On the contrary he made her the prototype of all women, whom he saw as powerful, threatening, deceitful, and potentially destructive of men. Paruval did not remember well what his mother did to him directly, but he remembered well what the

father had to go through with her. Thus he lived in terror of having a fate similar to that of his father. Considering himself weaker than his father, he expected a worse destiny. What he reported as having heard when he was in his twenties about his first love, Alicia, was a forerunner of what was to come later. Of course, we do not know how much distortion was already in his own report or memory of the Alicia episode. His basic underlying philosophy or unconscious premise that any responsibility for whatever is uncertain, untrustworthy, and painful in family relations resides in women.

Although he mentioned the mother quite often in relation to what the father had to tolerate from her during the patient's adolescence and youth, he never became very vehement about the mother. He spoke of her with a sense of resignation and simplicity. "Father decided to accept. That was his life." But what the patient did not openly feel and express about his mother, he felt prone to feel and express about his own wife, whom he despised but never divorced.

What makes him a paranoiac rather than a paranoid is the way he sustained his delusionary beliefs. There were no hallucinations or paleologic thinking. He was interpreting logically, although with false

premises, certain events in such a way as to prove the central themes that his wife was untrustworthy and was doing things for the purpose of hurting him. His reasoning power was used to transform a mere possibility into actuality.

Of course, we have to consider also what role the wife played. In my opinion the paranoiac structure resided in the patient himself. However, the wife enhanced and perhaps made possible the perpetuation of the disorder, thus giving a Pirandellian flavor to the family situation. Why did she open the mail? I do not believe that we have here the usual schizophrenic *folie a deux,* where one patient is the inductor and the other a passive recipient of delusions (see Chapter 11). In the paranoiac family situation generally the second member is an active participant. His or her participation, however, is not enough to explain the origin of the condition, but it is sufficient at least in some cases to explain its prolongation and its exacerbation.

Although psychotherapy of mild paranoia is successful in diminishing the intensity of the exacerbations and in preventing future attacks, psychotherapy is ineffective in cases of severe paranoia. At times the diagnosis between the mild and the severe type is

impossible to make because there are many intermediary stages. This diagnostic difficulty presents one of the most serious problems in the practice of psychiatry because whereas most cases of mild paranoia cause pain only to the sufferer and his immediate family (unless, of course, the patients become politicians), cases of severe paranoia are dangerous to others. Under the effect of delusional ideas the patient may even murder the alleged persecutors.

Paranoiacs present great practical problems not only for psychiatrists but also for lawyers. Especially the litigant type consults many lawyers in the hope that they would believe his claims and help him to sue or to obtain vindication (Revitch and Hayden, 1960).

II
Anorexia Nervosa

Anorexia nervosa is a condition that is often confused or associated with schizophrenia. It affects almost exclusively girls from puberty to the late twenties. Clinical evidence suggests that anorexia is not necessarily a schizophrenic syndrome or a precursor of schizophrenia. However, inasmuch as a certain number of cases, by far superior to statistical probabilities, shows an evolvement to definite

schizophrenia, we must think that the two disorders are related.

The relation between weight and psychosis has been amply studied by Bruch (1957), more in relation to obesity than anorexia. According to her, progressive obesity in youngsters may be an expression of an underlying disturbance in adaptation: “It may be the first visible manifestation of a potential psychosis; the overeating and inactivity that bring about obesity serve as defenses against unbearable anxiety and situations which might arouse new conflicts." Bruch correctly states that overeating may be a mechanism of defense, and that growing obese and maintaining the weight may be of extraordinary importance for prepsychotics until new solutions have been found. Bruch reports that many schizophrenic psychoses have been precipitated by forcing a reduction in weight.

Anorexia nervosa is an even more challenging condition as patients may literally starve themselves to death. Patients refuse to eat and some of them, unless hospitalized and tube fed, do die of inanition.

Anorexia etymologically means lack of appetite, and therefore is a misnomer. Anorexic patients have indeed a strong appetite, but in

spite of it, they refuse to eat. There is a large literature on anorexia (Bruch, 1962; Meyer and Feldman, 1965; Thoma, 1967), but I shall follow the major ideas of Selvini (1963, 1970), who, in my opinion, has made outstanding contributions on this subject.

The patient reveals a determination to undernourish and emaciate herself in spite of her intense desire for food. At times she resists excruciating hunger, because she is afraid that if she eats, her body will expand, become obese, unappealing, or even monstrous and grotesque. Actually she becomes unappealing because she is very emaciated. She denies that she is very thin in spite of the evidence and in spite of keeping track of her weight regularly on a scale. That the patients knows that she is emaciated is also revealed by some drawings that she makes of herself and other people. Strangely, she states that her drawings do not portray emaciated persons. If she gains an ounce of weight, she considers this fact a great calamity and the beginning of her doom.

According to Selvini the patient is afraid of her body and of food, which once ingested becomes part of her growing body. Selvini writes that “for the anorexic patient to be a body means to be a thing. If the

body grows, the thing also grows at the expense of the person. Her fight against the body-thing is her fight against being a thing. A desperate fight, because, paradoxically, though refusing to be a thing, she fights her battle not at the level of spiritual values but rather at a material level, that of the body" (1970).

According to Selvini the patient equates her body with the incorporated object, namely the bad mother. The patient attributes to her body the qualities she attributes to the mother; namely, being powerful, indestructible, self-sufficient, growing, and threatening.

Selvini posits the question of why anorexia nervosa occurs almost exclusively in the female sex and around the time of puberty. She believes that when the patient's body develops larger breasts and other feminine curves, the patient unconsciously experiences it not as her own body but as the maternal object itself, which she has incorporated. This incorporation is not an identification with the mother. The aggression that the patient used to have for her mother is now directed against her own body. The patient must fight against her own body. The body "becomes the persecutor, but a persecutor whom it is easy to spy on and control. This projection onto the body is a

safeguard against interpersonal delusional ideas and thus somehow saves the capacity to socialize and to relate to the world." Schizophrenia is thus averted. Nevertheless, Selvini calls anorexia nervosa an "intrapersonal paranoia" because a delusion exists, although the projection involves one's own body rather than the external environment.

I am very much impressed by Selvini's psychodynamic analysis, which in my opinion was confirmed in the majority of cases I have treated. I doubt, however, whether we can call anorexia nervosa an intrapersonal paranoia or psychosis. Although I am convinced that the patient identifies her body with her mother and considers her body as the origin of her trouble, as a persecutor is often conceived, this mental attitude is completely unconscious. The patient would never say that her body is her persecutor. On the contrary, at a conscious level she believes that by eating she will harm her body. Thus she uses mechanisms that are more neurotic than psychotic. Nevertheless it is true that her attitude toward food and life in general are almost psychotic and may become psychotic.

In a certain number of patients who have come to my attention

there had been either a suspicion of schizophrenia or an actual history of short schizophrenic episodes. In one case there was a history of a withdrawal and almost catatonic immobility for many months. In several cases there were no manifestations of schizophrenia at any time. In all my cases there was no thyroid dysfunction, but rather amenorrhea.

Another differential characteristic between my cases and those of Selvini lies in the fact that in at least half of my patients periods of anorexia were alternated by periods of overeating. Some patients, when on an eating spree, would eat incessantly for many hours in a way that is hard to believe and could gain even ten pounds in a single day. A few days later the same patients could go on a self-imposed regime of almost total fasting. This periodicity in some cases was reminiscent of that seen in typical cases of circular manic-depressive psychosis.

III
Childhood Schizophrenia

Childhood schizophrenia was first described between 1905 and 1908 by De Sanctis, who called it dementia praecocissima (De Sanctis,

1925). Many important subsequent studies of this condition have been made, such as those of Potter (1933), Bradley (1941), Bender (1947), Mahler (1952, 1968), Despert (1941, 1968), Goldfarb (1961), Szurek and Berlin (1973).

No attempt will be made here to treat fully this important topic. Our main interest is to study whether childhood schizophrenia is related to adult schizophrenia or is an independent clinical entity. The following remarks are abstracted from the major available works on the subject and are intended to be of integrative character to the main topic of this volume.

Three types of child schizophrenia are described: (1) autism; (2) symbiotic psychosis syndrome; (3) forms of psychosis similar to adult schizophrenia.

Autism is generally associated with Kanner (1944, 1946) who first described it under the name of early infantile autism. This condition is characterized by special attitude toward people and by a serious thinking disorder. From the time he has learned to walk, the child seems to run away from personal contacts. Extreme aloofness is

present. Often rather than aloofness there is a denial of the existence of other human beings. The child does not seem to see or hear adults or in any way acknowledge their presence. For instance, Kanner reports that if one of these children is pricked with a pin, the child is aware of the pin, and perhaps of the hand that holds it, but not of the person who pricked him. In a later paper Kanner (1965) wrote that perhaps autism is not the proper name for this condition. Referring to autistic children he wrote:

> While they are remote from affective and communicative contact with people, they develop a remarkable and not unskillful relationship to the inanimate environment. They can cling to things tenaciously, manipulate them adroitly, go into ecstasies when toys are moved or spun around by them, and become angry when objects do not yield readily to expected performance. Indeed, they are so concerned with the external world that they watch with tense alertness to make sure that their surroundings remain static, that the totality of an experience is reiterated with its constituent details, often in full photographic and phonic identity.

These children are either mute or, if they speak, they do so in a peculiar way. One of the common characteristics is the fact that they use pronouns just as they hear them. If the child is told by his mother,

"I will give you some soup," the child subsequently expresses the desire for the soup in exactly the same way. He speaks of himself as "you" and not too infrequently of the mother as "I." That is, he uses the same pronouns as his mother would use. The child does not see those reflections coming from the adults around him as related to his self. The "you" remains a "you" and is not transformed into "I"; it somehow remains a foreign body.

The expressions used by these children seem irrelevant or completely nonsensical and resemble those of some adult schizophrenics. Kanner gives many examples of these expressions, which he calls "metaphorical" in the sense that they represent "figures of speech by means of which one thing is put for another which it only resembles" (1944, 1946). Kanner reports that the transfer of meaning in these expressions is accomplished in a variety of ways: (1) through substitutive analogy, in which for example, breadbasket becomes "home bakery"; (2) through generalization, or *totum pro parte,* in which "home bakery" becomes the term for every basket; (3) through restrictions, or *pars pro toto*—such as, when the number 6 is referred to as "hexagon."

These examples given by Kanner represent typical paleologic expressions and may be reinterpreted in accordance with Von Domarus's principle, which implies substitutive analogy, generalization, and restriction (Chapter 16).

Kanner considers these children austistic and does not call them schizophrenics, in spite of certain similarities in thinking. These children present stereotyped utterances, neologisms, and withdrawal. However, they do not have symptoms like delusions, hallucinations, ideas of reference, catatonia, and so forth, as reported in many descriptions of child schizophrenia, such as those given by De Sanctis (1925), Potter (1933), Bradley (1941), and Kanner himself (1942). In addition, and this is an important point, there was no evidence that these children had reached a normal or relatively normal adjustment after the age of 2. On the contrary, since that age there had been some disturbance in their mental integration and especially in their process of socialization. In other words, there seems to be no real schizophrenic regression in these children, but there is an inability to develop interpersonally beyond the level of 1½ to 2½ years of age. Instead, children who develop a schizophrenic syndrome more or less similar to that found in adults are able to integrate or socialize better

after the age of 2 and have already learned to use language normally before the mental disorder starts.

According to Mahler and colleagues (1959) and to Mahler (1968) autism is a defense of children who cannot use or experience the mother as the living primary-object. According to her, autism is an attempt at dedifferentiation and deanimation. The children behave as if they were still in the first few weeks of life, in a "normal autistic phase in which the distance receptors are not yet functionally tuned."

The parents of these children are described as generally cold, detached, obsessive, and intelligent people. Abnormalities in electroencephalogram, neurological or other physical ailments, and frequency of mental disease in the family do not seem more frequent than in the general population.

The etiology of autism has not been clarified. Eisenberg and Kanner (1957), after many years of investigation, wrote: "It is difficult to escape the conclusion that the emotional configuration in the home plays a dynamic role in the genesis of autism." Rimland (1964) believes "that there is sufficient information at hand to demonstrate

clearly that early infantile autism is not the same disease or cluster of diseases which has come to be called childhood schizophrenia." Kanner (1965) states: ". . .we can state unreservedly that, whether or not autism is viewed as a member of the species schizophrenia, it does represent a definitely distinguishable disease. This disease, specific—that is, unique, unduplicated—in its manifestations, can be explored *per se.* The emotional configuration in the home plays a dynamic role in the genesis of autism." Bettelheim (1967, 1970) does not deny organicity, although he tends to give great importance to psychogenic factors. According to him, an unremitting fear for their lives compels these children to withdraw and defend themselves in the "empty fortress" of autism.

The symbiotic psychosis syndrome is also called the Mahler syndrome, because Mahler first described it. The child has reached a degree of development in which he is able to differentiate and individualize from the mother, but he cannot proceed to a full separation. Panic results whenever separation is attempted. According to Mahler, "the symbiotic psychotic syndrome is aimed at restoring the symbiotic-parasitic delusion of oneness with the mother and thus serves a function diametrically opposite to that of the autistic

mechanism." According to Mahler the psychosis may be insidious and may remain undiagnosed until school age, or it may be acute and sudden. The clinical picture is characterized chiefly by catatonic-like temper tantrums and states of panic. According to Mahler some feverish attempts to recontact reality seem to perpetuate the delusional omnipotence phase of the mother-infant fusion of the first year.

Other psychotic syndromes resembling adult schizophrenia, with hallucinations, delusions, and ideas of reference, have been described by many authors, generally in children not younger than 8 years of age. If these patients were older, they would be indistinguishable from cases of adult schizophrenia.

Bender considers every type of child schizophrenia to be based on biological alterations and at least until 1953 recommended electric shock (1947, 1953). Bender found in most children whom she diagnosed as schizophrenics such conditions as disordered respirations, persistence of primitive postural and righting reflexes, as demonstrated by the "whirling test." In this test the child closes his eyes and stands with his arms extended and parallel to each other. In a

positive response, when the child's head is turned as far as possible, the child turns his body in the direction in which the head turned. In a negative response the child does not turn his body.

We may conclude by stating that the three conditions discussed in this chapter—paranoia, anorexia nervosa, and childhood schizophrenia in its subvarieties—are symptomatologically and psychodynamically very much related to schizophrenia and must be taken into consideration in any study that views schizophrenia in its largest scope. Certainly they are more related to schizophrenia than such conditions as depression, hysteria, or psychosomatic gastric ulcer. Nevertheless, as long as our knowledge of psychiatric syndromes remains as unsettled as it is, it is preferable to retain the concepts of these three conditions as separate clinical entities. Psychogenic factors appear important in all of them. Organicity is suspected in childhood schizophrenia much more than in all the other syndromes, including adult schizophrenia. Paradoxically the genetic evidence for such suspicion is even more unreliable than for adult schizophrenia.

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