INTERPRETATION OF SCHIZOPHRENIA

The Prevention of Schizophrenia

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I
Introduction

To whomever is concerned with schizophrenia nothing can be more important than its prevention. In the field of psychiatry preventive medicine has made tremendous progress in at least three areas: (1) psychosis due to pellagra; (2) general paresis; (3) delirium due to infective conditions. Respectively, niamin- and thiamine-enriched diet, antisyphilitic treatment, and sulfonamides and antibiotics are responsible for these remarkable achievements. In schizophrenia the etiology is more complicated and completely different from that of the mentioned conditions. Because of our incomplete knowledge, our preventive efforts are less prominent, and what is exposed in this chapter does not achieve a degree of clarity approximating our aspirations. Nevertheless, pioneering efforts are always justifiable and deserve full consideration.

In the last few years in psychiatry, too, it has become customary

to speak of primary, secondary, and tertiary prevention. Primary prevention aims at lowering the incidence (or making less probable the onset) of psychiatric disorders. Secondary prevention aims at the early recognition of the disorder in order to institute the promptest and most effective treatment. Tertiary prevention aims at reducing the defect caused or left by the disorder. Secondary and tertiary preventions are discussed in Chapters 3 and 4, dealing with the diagnosis, as well as in Parts Seven and Eight, dealing with the treatment. This chapter is devoted only to *primary prevention.*

Under the heading of primary prevention of schizophrenia I distinguish three types:

1. *Basic prevention,* which aims at the elimination of those prerequisites, either hereditary or environmental, that create a potentiality or increase the vulnerability for the disorder.

2. *Longitudinal prevention,* which aims at assisting the individual throughout his life, especially in his early life, to avoid those vicissitudes, psychogenic developments, or enduring situations that will enhance the change from a potentiality for, to a clinical actualization of, schizophrenia.

3. *Critical prevention,* which aims at avoiding those factors or specific events that will precipitate an attack or onset of schizophrenia.

What has been illustrated in this book has demonstrated that although no absolute or beyond-doubt knowledge has been acquired about the etiology of schizophrenia, the presumptive knowledge that we possess is extensive and is convincing enough to enable us to put into effect many presumably preventive measures.

II
Basic Prevention

Genetics

The studies reported in Chapter 27 have provided some evidence that a potential for schizophrenia has a hereditary basis. Schizophrenia is not inherited—only a potentiality for it. A possibility of prevention thus would consist of making impossible such genetic potentiality, so that even if individuals were exposed to the most traumatic psychological experiences, they could not develop the psychosis. However, it is almost impossible, as well as undesirable, to implement eugenic measures. In relation to schizophrenia we find

ourselves in a situation quite different from that with which we are confronted in relation to the well-known hereditary diseases. In a family where Huntington's chorea, muscular dystrophy, hemophilia, and other unquestionably hereditary conditions exist, the physician can easily explain to the individual the Mendelian inheritance, either dominant or recessive, and the risk involved for possible offspring. In the case of schizophrenia similar genetic counseling is impossible. The counselor can only say that if a parent has been a schizophrenic, the potentiality for schizophrenia presumably increases ten times for children. In spite of the increased risk, the child has a 90 percent probability of not developing schizophrenia. As we have seen in Chapter 27, the potentiality for schizophrenia is presumably checked or neutralized by healthy environmental contingencies.

If it is not easy to prevent marriages of people who are carriers of definite dominant or recessive hereditary diseases, it is much more difficult to do so in the case of schizophrenia when the available literature seems to guarantee a 90 percent protection. In other words, if a person is or has been a schizophrenic, he has a 10 percent chance of being a carrier of schizophrenia. If an individual had a parent who was a schizophrenic, he also has a 10 percent chance of becoming a

schizophrenic. The probability exists that if other preventive psychological measures are followed, the 10 percent potentiality will never become actuality. The fact that the statistics are not so overwhelming and the possibility that environmental factors may neutralize them completely will induce people to follow love and moral considerations rather than the genetic risk. Moreover, the individual may be strengthened in his or her determination to provide a good environment and may undergo preventive psychotherapy. Lifetime birth control, voluntary sterilization, or therapeutic abortion cannot be authoritatively recommended in the presence of such relatively little risk. Such measures should be recommended, however, when both spouses are or have been schizophrenics, because statistics indicate that in these cases the risk of offspring developing schizophrenia is very high (from 50 to 68 percent).

One must also realize that the great progress made in the treatment of schizophrenia will increase the genetic potentiality of the disorder. In fact, the more effective is the treatment and the greater is the percentage of patients who recover or greatly improve, the greater will be their reproductivity and the rate of transmission of genetic potentiality.

The following conclusions can be drawn:

1. It is difficult to counsel against marriage for people with a possible hereditary predisposition to schizophrenia unless a great risk is involved, as is the case of two prospective parents who have both suffered or are suffering from the disorder.

2. When a hereditary potentiality for schizophrenia exists, counseling should be given in order to establish a favorable family milieu and decrease the risk of the disorder.

Early Psychogenic Environment

What we have exposed in Part Two of this volume indicates that an early psychogenic environment is essential for the occurrence of schizophrenia, for transforming whatever genetic potentiality exists into an actuality. The basic function of primary prevention must consist of hindering the establishment of this early psychogenic environment (e.p.e.). As we have repeatedly stated, at the present time nothing can be suggested that is supported by unquestionable proof. What is available is only presumptive evidence.

Parents' Marriage. In my opinion the unhappy marriage of the

parents is one of the fundamental determinants of the e.p.e. Needless to say, the preexisting disturbing personalities of the parents constitute original factors, but whatever is negative in the personality of each parent tends to become accentuated in an unhappy marital situation. It is true that there are many unhappy marriages and that relatively few of these have schizophrenic offspring. Not only the genetic potentiality must be there and many other circumstances, but the unhappy marriage must be pathogenic in the sense of not permitting the child to identify satisfactorily with either parent or to obtain a modicum of security and basic trust.

A survey of families of schizophrenic patients will easily reveal that marital unhappiness is more common and more pronounced than in the families of the general population (see Chapter 5). There are apparent exceptions. At times the illness of the patient confers a feeling of solidarity to the parents and reinforces their bond. These are usually late events and in most cases are more harmful to the patient than helpful. No situation that requires the patient to be ill in order to maintain itself is genuine or worthwhile.

Premarital counseling aiming at uncovering basic

incompatibilities and prevention of unions based on neurotic foundations will be useful. Premarital counseling may also prevent marital unhappiness by clarifying what is expected from people who enter a marital relationship.

Parenthood. Unhappily married people may find psychological satisfaction and compensation in raising children, especially in some cultures where parenthood is considered the most important aspect of marriage. Consequently children are not seriously impaired. On the other hand, in a culture where the significance or importance of parenthood is diminished or secondary to marital harmony and kinship, unhappily married people tend also to be poor parents. From the time of the industrial revolution to the present, and especially since technological changes have taken place at a very rapid pace, our culture and society have been in a state of transition. There have been changes in the roles of mother and father that constitute threats to parenthood. When these cultural factors are reinforced by personality difficulties, the consequences may be undesirable.

In Chapter 32 we have seen that the woman has lost many traditional values and functions. At the same time she has recognized,

even if until very recently she has not openly expressed, her resentment over the fact that in a predominantly patriarchal society she has often been considered a second-class citizen and has not been given opportunities equal to those given to men. In her efforts to achieve equality she now diverts some of her interests from the functions of housewife and seeks a career as a man does. She is certainly entitled and justified. But just as society failed her before for putting her in a state of submission, it fails her now for not preparing her adequately for a double role. The task is indeed difficult and sociologists should study the problem more adequately, not just along theoretical lines but with practical suggestions. Married women must have a feeling of fulfillment. Otherwise they will experience frustration and will have the compulsive need to compete with their husbands, with resulting family unhappiness.

One function that the woman cannot dispense with is motherhood. But for the sake of this function she should not be required to give up many other important aspects of life.

The reader is referred again to the description in Chapter 32 of a certain group of mothers in the urban-industrial society. In this

environment many young women have not been sufficiently prepared for motherhood. Some of them see no beauty or challenge in being mothers. They state that even female animals can be mothers and raise a litter, as if raising a human child were as simple as raising a kitten. Obviously these women should not be criticized or abandoned but helped to reevaluate their role of motherhood while maintaining the possibility of a career. In our modern Western society, which aims at gender equality, the role of the father should also be redefined, and many of the functions originally assigned exclusively to women should be more fairly distributed.

Of course, focusing on a career and competing with men are not the only reasons that make preparation for motherhood more difficult. Shainess (1966) has lucidly illustrated the psychological problems associated with motherhood. She reminds us of Freud's stress on the woman's dual sexual role (Freud, 1931) and its psychological consequences: first, attracting and having a sexual relationship with a man; second, giving birth to children and assuming the mothering task. Success in one role does not necessarily imply success in the other. Some poor mothers are successful only in the first role; many poor mothers, however, are not successful in either. They enter

marriage expecting a great deal and are not prepared to give in return. They assume an attitude of passivity, as if the spouse were a new parent who will take care of them. After the arrival of the child, some of these mothers experience motherhood as a stress. As Shainess writes, the ambivalence or the rejection become hatred because of the insoluble tie.

Culture as a whole should help young women to reacquire a sense of devotion toward motherhood. Young girls in high school and college and other fields should receive some counseling and education because many of them, in our transitional times, did not learn adequately by identifying with their own mothers. Courses, theoretical indoctrinations, and even counseling offered in a scholastic setup may appear dogmatic, scientific, and nonspontaneous methods of instilling love for motherhood. They can very easily be. The present state of affairs, however, is that a certain part of our female population has lost that spontaneous, pristine, natural attitude toward motherhood, which used to be transmitted from generation to generation. Until some women have recognized this socially induced situation, we must resort to any method that can help them.

Shainess states that acceptance or rejection of the child is an acting out, automatic or compulsive, stemming from unconscious sources. Unless the unconscious forces for acceptance are retrieved, society must try to find compensations for the loss of them.

Fatherhood, too, has become less satisfactory since the time of the industrial revolution. Mitscherlich (1969) and Mitscherlich and Mitscherlich (1973) have described ‘ ‘the invisible father’ ’ in our society. The father is no longer the teacher, the senior partner in artisanry. He has lost authority not only as a teacher of life but also as an enforcer of discipline, as a giver of examples to imitate, a person with whom the children can identify. Often he is relegated to the role of a playmate. He sees the children seldom, and when he sees them, he wants to be one of them, to play with them, to be their peer. But in doing so he soon loses his parental status. Obviously in the state of change in which present society is, fatherhood has to undergo transformation. Not all the changes described by the Mitscherlichs are necessarily negative. However, modern fathers have not yet defined their new role, and this state of indecision may lead to conflict and family instability. Like modern mothers, modern fathers, too, need help. Help should also be provided for future fathers, similar to that

suggested for future mothers.

In summary, at the present state of our knowledge it seems probable that the establishment of the e.p.e. can be avoided by all those sociological and psychological measures which (1) prevent unhappy marriages and (2) promote good motherhood and fatherhood.

III
Longitudinal Prevention

Longitudinal prevention is to a large extent to be inferred from what we have learned in Part Two about the psychodynamics of the disorder, and to a smaller degree from Chapter 32. Longitudinal prevention must aim (1) at altering the original e.p.e. and its effects and (2) at affecting social conditions in such ways that the essential needs are more easily provided to the child, adolescent, and young adult and that unusual stress does not exceed the capacity of the individual to cope with it.

Implementing longitudinal prevention is extremely difficult because of the reluctance of the family to allow professional

intervention before the need is manifest and because of the attitude of indifference of society and in some environments even of the medical and educational authorities, toward psychological problems. In most schools, from nursery to postgraduate, a routine physical medical examination is required. I think that a psychiatric or psychological examination should also be required, at least in grammar schools and high schools, with the obligation of informing the parents or guardians of the results. If the examiner detects the first signs of personal abnormalities, or of an abnormal way of living, he may intervene in three ways: (1) by requesting individual psychotherapy for the student; (2) by suggesting counseling, family therapy, or therapy of the parents (these methods will reveal not only pathogenic mechanisms easily accessible but also the unconscious ones that cause or facilitate the perpetuation of faulty patterns of living); and (3) by suggesting changes in the environment of the child, adolescent, young adult, or adult. In some cases it is useful to enlarge the family circle. As we have already mentioned, in the traditional family the child was exposed to many influences: not only to parents and one or two siblings, but to several siblings, grandparents, uncles, aunts, cousins, maids, and various other persons. Today the family, especially in large cities,

consists of the parents and one or two children. Thus there is no possibility of compensation for the children or of identifying with other individuals if the parents are unfit.

In many cases the examiner can recommend that the child or adolescent be under the influence of additional adults, not just of the parents. An aunt, an uncle, a maid, a good friend of the family may veer the youngster toward a good interpersonal integration. The idea that the parents must be the only ones to do the job is unrealistic when they are not willing to accept therapy or counseling or when they are unable to benefit from them. In several cases the mother may remain an important person for the youngster, but the role of motherhood must be divided with other adults and a peer group. The experience reported from the kibbutzim in Israel may give valuable suggestions. While the mother goes to work, a so-called *metapelet* (that is, "a person who takes care") is in charge of the child and exerts the functions of mothering. Bettelheim (1969) made an intense study of children born and raised in kibbutzim and reported that he encountered no schizophrenics among these children. Such a remarkable statement is unfortunately made by Bettelheim only in passing. We would like to be certain that his not encountering

schizophrenics among these children really corresponds to the absence of schizophrenia among them. While I was visiting kibbutzim in Israel, I found support for Bettelheim's statements. I became convinced, although without the support of statistics, that schizophrenia was rare there. What Bettelheim says to explain his findings is very interesting and deserves deep consideration. He reminds us that a small but good amount of mothering, as that given by the real mother in the kibbutz, goes a long way. Once the breast feeding from the mother stops, it is the *metapelet* who provides food, shelter, rest, stimulation, clothing. The parents continue to provide the extras and a special warmth. That is, whereas the *metapelet* provides mostly the physical essentials for survival (and some instinctual gratification), the parent provides "love and tender care." In other words, security originates not only from the parent, but also from the several *metapelets* and the large group, the kibbutz itself, a community of peers.

What we can learn from the kibbutz experience is that a nonparental influence may be very useful. When the examiner or the counselor detects poor parenthood, he may suggest that the youngster be under diversified influence and a person acting as a *metapelet* must

be found.

Separation from the family may be recommended in some instances. Whatever measure could remove the tension, the anxiety, the hostility, the conflicts of loyalty between antagonistic groups of the family, or the tyrannical attitude of some members and the submission of others, should be adopted.

The youngster can also be assisted with his feelings of frustration and defeat that come from aspirations not commensurate with his abilities, from poor interpersonal relations, lack of knowledge in dealing with the opposite sex, first romantic disappointments, inability to suppress one's homosexuality, and so forth. Such assistance is generally not given if the need for it is not discovered. Mandatory examinations would make more likely the use of counseling or therapy.

The social conditions described in Chapter 32, which generally are associated with an increased rate in schizophrenia, are difficult to change. Of course, we are all in favor of measures such as adequate housing with sufficient space and facilities, war on poverty and

unemployment, fight against disease, anomie, crime, drug addiction, alcoholism, prejudice, and so on. Much more difficult to affect are such phenomena as emigration, migration to another part of the same country, social mobility, and so on. Moreover, although it is true that some of these events determine an increased rate of schizophrenia, in many other cases they strengthen the character and personality of the individual. They renew his vitality and creativity and make him rise to the challenge.

IV
Critical Prevention

Critical prevention consists of dealing with the patient in the presence of a critical situation that is likely to precipitate a schizophrenic episode. The first question is whether it is worthwhile or feasible to attempt this type of prevention. One may think that the critical and possibly precipitating event may be only the straw that broke the camel's back and that we cannot go through life avoiding or compensating for all possible straws. We have seen in Chapter 8 that this is not the case. Although it is true that the ground for the psychosis must be prepared genetically and psychologically, *any*

stressing event is not a precipitating event. It must be one that is intimately related to the psychodynamic of the patient, one that will affect his special vulnerability and will injure deeply his self-image. Without a particular precipitating event the psychosis may never occur, although the patient may remain maladjusted for his span of life. To resort to a metaphorical example: a war is probably prepared by a deeply unstable political situation and social unrest or malaise, but unless a specific incident or unpleasant episode occurs, it may never be declared or waged. Some people believe that if a psychosis, especially of the acute type, is threatening, it is better to have it, endure it, and get it over with. The patient, once recovered, would be strengthened and better off than if he lived with an ever-impending psychosis or serious maladjustment. In my opinion this is fallacious reasoning. Although it is undeniable that many patients are in a much better condition after having had the psychosis and a successful treatment, we must remember that this outcome is unpredictable. Some patients do not respond fully to treatment, others retain scars, others remain crippled and incapacitated for the rest of their lives. Some who seem recovered have relapses. It would be like saying that it is a good thing to go to war because when you return, your character

will be strengthened. What about those who are wounded, cripples, maimed physically or psychologically, or who do not return at all?

The second question is whether it is better to avoid the precipitating event, the challenge the patient tries to cope with. In many cases it is impossible to avoid facing the challenges. To restrict the patient's actions would mean to control the constitutional rights of the individual. To prevent him from taking certain steps would be tantamount to inflicting a demoralizing feeling that may also precipitate the psychosis. Among such events are the following: going away from home to college or to work; becoming engaged, married, or having a baby; changing school or job; going on an adventurous trip; being promoted; breaking an engagement, a marriage, a long relationship, and so forth. It is not correct to assert that these events cannot precipitate a psychosis; that is to say, that only novelists and playwrights have such viewpoints about what brings about a psychosis. Clinical experience confirms that these events may produce an imbalance between the demands of the immediate challenge and the psychological resources of the individual. It is true that had the ground not been prepared genetically and psychodynamically, the challenge would not have produced the imbalance. Nevertheless we

cannot deny the effect of the challenge itself.

In some cases, like the one brought about by a promotion, the challenge may be one ordinarily considered a good event. It may thus *seem* that preschizophrenic patients are not able to cope even with good events. Good events, even those not accompanied by great challenges, may disturb the equilibrium also of partially recovered schizophrenics and may cause relapses. Anxiety about failing after having obtained success is more difficult to bear.

Using the formulation of Caplan (1964) we may say that in order to prevent life crises we must provide: (1) attenuation of hazardous circumstances; (2) services to foster healthy coping. This is generally done with interpersonal intervention.

We cannot discuss here all the situations that can precipitate a schizophrenic episode. The reader is referred to Caplan's book (1964) for a detailed study of prevention of all mental disorders in life's critical situations. Here we shall mention only: (1) the college situation; (2) pregnancy and, much more frequently, childbirth.

It is easy to understand the difficulty of the youngster who for the

first time leaves home to go to a college and live on his own. He may feel deprived of the protective environment in which he grew; he has to face the challenge not only of living alone but also of increased scholastic demands. Obviously most young people take all this in their stride, and even with a sense of jubilation; but if the youngster is psychologically unstable, his anxiety may reach disturbing proportions. Although some unstable teenagers fare better away from disturbed homes, some do much worse. The early environment, although in some ways destructive, was also protective; and the protective aspect succeeded in hiding or compensating for the destructive.

At times the youngster experiences a sudden increase of anxiety and sends desperate appeals to the family by letters and telephone calls. Those appeals should not be dismissed with the formula "John will learn to grow up and to be on his own," but should be heeded. Intervention from family, friends, advisors, teachers, or whoever notices a disturbing change in the individual in question may be very helpful. The youngster who is confronted with a crisis he does not know how to deal with, at times is prone to take unusual actions in an attempt to decrease his anxiety. These actions are maladaptive and

could do much harm—for example, excessive marijuana smoking, use of LSD, traveling aimlessly to different parts of the country, taking steps to change schools, and so on. Whoever notices a deterioration in the student's habits should inform the teachers or the family. Often a disintegration of psychotic proportions is preceded by several signs of minor disorganization such as inability to sleep at night, staying in bed for the whole day, inability to take action, state of starvation or excessive appetite, neglect of appearance, and so forth. If the intervention occurs before the crisis has triggered the psychosis, the prognosis is relatively good. The disturbed person is easily influenced by a stable, warm, reassuring, and, most of all, understanding and non condemnatory person. In many instances the patient is not able to verbalize the negative experiences he undergoes. The intervening person must be patient and reassuring and must do most of the talking. Teachers and advisors should be on the alert for the mentioned signs of disorganization. Whenever doubt exists, the family should be notified and a psychiatric consultation recommended. Even after the occurrence of the psychotic episode, prompt intervention from scholastic authorities or from colleagues may be very useful (see case of Fred in Chapter 22). This intervention or vigilance on the part

of scholastic authority is not always easy, because it may give the impression that a "spy system" is at work and thus may facilitate paranoid tendencies. Reassurance should be given that the rules of confidentiality will be respected.

Pregnancy and childbirth may engender crises that precipitate a psychosis. We have already dealt with this important topic in Chapter 13. Shainess's paper (1966) should also be consulted in this respect.

In his book on nonpsychotic French women who had recently given birth, Chertok (1969) describes "the choices of the negative." His clinical experience showed him that for the pregnant woman it was easier to perceive "what is wrong" than "what is right." He wrote that "the effectiveness of the integration of past conflicts and the strength and dynamic force of the ego are very difficult to assess in view of the widespread reactivation that takes place during the *state of crisis."* When what he called "the negative grid," or the constellation of all negative experiences and factors, was very marked, prophylactic therapy had a beneficial effect on the confinement. Although Chertok dealt only with nonpsychotic women, his recommendations seem even more pertinent to the prepsychotic pregnant woman. It is impossible,

of course, to require from the average obstetrician a psychiatric examination of all his patients. However, when he detects a strong negative attitude toward pregnancy, motherhood, or life in general, a psychiatric examination should be recommended.

Some authors like Freeman (1951) and Wainwright (1966) have reported that the arrival of the baby precipitates mental illness (more often depression, but also schizophrenia) in the father too. The presence of an infant in the household markedly changes the lives of both parents. Reactivation of serious old conflicts in the husband of an expectant mother is sufficient reason to justify seeking counseling or psychotherapy.

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"Special Logic of Schizophrenic and Other Types of Autistic Thought." *Psychiatry,* Vol. 11, 1948, pp. 325-338.

"The 'Placing into Mouth' and Coprophagic Habits." *Journal of Nervous and Mental Disease.* Vol. 99, 1944, pp. 959-964.

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"The Possibility of Psychosomatic Involvement of the Central Nervous System in Schizophrenia." *Journal of Nervous and Mental Disease,* Vol. 123, 1956, pp. 324-333.

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"Schizophrenic Art and Its Relationship to Modern Art," *Journal of the American Academy of Psychoanalysis,* Vol. 1, pp. 333-365. © 1973 by John Wiley & Sons.

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