Family Interrelationships and Their Bearing Upon the Development of Psychotic Conditions

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Only extremists will still insist that psychotic conditions are the result of one etiological factor. Even if this factor is found to be hereditary or environmental, toxic or bacterial, allergic or constitutional, it will still have to be explained why a causative agent to which many are exposed causes manifestations only in a fraction of them. The theory of an individually or temporarily lowered resistance still is accepted with some reservations. Predisposition as a precipitating factor of psychotic conditions has been disclaimed by the study on identical and non-identical twins. This latter research work has proved that different environmental conditions and especially superior surroundings have helped to raise the I.Q. of the particular identical twin in some cases as much as 19 points.[1]

In a study of the intelligence, school achievement and conduct of foster children, Freeman[2] gave the following survey of the "changes in the I. Q. of orphanage children removed to superior and inferior foster homes":

Group	No. of cases	Av. Age 1st test	Av. Age 2nd test	Av. I.Q. 1st test	Av. I.Q. 2nd test	Av. Changes in I.Q.
Removed to sup. homes	33	7 yrs. 8 mos.	11 yrs. 11 mos.	95.2	100.5	5.3
Removed to inf. homes	41	8 yrs. 3 mos.	12 yrs. 4 mos.	88.0	88.1	0.1

Authors such as Skodak[3], Wellman[4] and others reported that an average increase of 9.8 points of the I. Q. of foster children was found by the end of two years in foster homes with a family background superior in intelligence and educational level. The authors stress in particular "the stimulating effect of the superior environment." As to psychotic conditions in identical twins, the fact that, according to Rosanoff[5], in only 32 per cent of 41 pairs both of the twins were affected, whereas in the remaining 68 per cent only one twin was affected, does not speak for predisposition as a factor in the development of psychotic states.

By coincidence I became acquainted with a number of cases where an anamnesis which revealed mental tainting in the family seemed to be combined with a family interrelationship which was similar to that of another group of patients with a negative family history. Both groups show cases with insidious onset and others where the psychosis arose

quite unexpectedly. The patients themselves and their relatives frequently pointed to the discordant family interrelationship as the cause of their psychotic state. Even if we assume that this psychogenic element may not be the etiological factor in itself, we will not fail to consider it a precipitating factor.

We cannot deny that the family condition in which the young individual grows up is of paramount importance in the development of his attitude and bearing, the sum of which we call his personality pattern. He will be molded by the family interrelationship to which he is exposed during his formative years, and it will even leave its imprint in his self-styled adult pattern. He will reveal traits and characteristics of this important potentiality of his development which will be the more marked, the more poignant the precept was to which he was conditioned. Such a similarity is sometimes striking, and we should be on guard against the conception that this resemblance in the young individual's mental and emotional make-up is the result of inheritance.

Dr. Benjamin Pollack[6] points to this fact when he states "Too often heredity is blamed for faulty habits. We hear that the child's grandparents were nervous as though that were an explanation for the child's faulty behavior. This is true to some extent, but chiefly in the fact that the behavior or the personality of the child is a mirror of the degree of adjustment of the parents and other members of the family."

With this concept in mind, the so-called suicide families may serve as example. In some families this incident is surrounded by a kind of dramatization which people like to link to morbid trends. The tendency to commit suicide may conceal a certain tainting of this particular lineage. It may become the orthodox manifestation of their feelings of insecurity and inadequacy and as such may be considered an inherited morbid character trait. The members of these families often live in terror of the shadow of their unfavorable inheritance, finally convinced that they, too, have to end in suicide. This fatalistic attitude, however, has nothing to do with inheritance or predisposition, as the following two cases show.

The first case is that of a female patient, 19 years old, who never attempted suicide, but numerous times thought of it. Her mother became alarmed when she found suicide threats in the patient's diary. There was a paternal aunt who had committed suicide at about the age of nineteen. She was the father's only and younger sister, and the patient became increasingly irritable in approaching the "fateful" age. No one in the family knew exactly of the reasons for this incident, and a kind of legend surrounded it. There existed a picture of the deceased, well hidden from the father. Many times the patient had tried to get hold of the picture, and when she at last found it she started to take keen delight in imagining the legends which would be woven around her as they surrounded her beautiful late aunt. The attention and interest of her

relatives, of which she felt frustrated all her life, would fall to her, at last. We find this kind of immature ideation more often among suicidal candidates than we would expect.

Another case is even more characteristic, because this patient attempted suicide three times in situations with which she thought herself unable to cope. She told about the suicide tendency in her family as follows: "Whenever my mother became emotionally upset, and this happened rather frequently, she would threaten to commit suicide, adding, however, that only my existence prevented her from doing so. My father and I lived in constant fear that this would come true one day. We knew that her mother had been suicidal for a long time and that a sister of hers had committed suicide. This all was kept from me for some time. I, nevertheless, learned of it, and both incidents were served to me with all details. It made me very unhappy to hear my relatives pass remarks that I resembled my grandmother and my aunt not only in appearance, but also in my mental make-up. I was intelligent enough to realize that I could be a suicidal candidate also, and from this time on I played with this thought whenever I encountered difficulties."

What has just been said about the so-called suicide families is true also for families stigmatized by mental or nervous tainting. The idea that all mental conditions are inherited is a widespread one, although up to now ill-founded. The thought of the inheritance of mental conditions seems to impend upon the unhappy ones; disrupts their reputations, lowers considerably their self-confidence and often disentangles their family relations. Since we have no proof as yet, the acceptance of the inheritance of mental conditions may cause more damage than it may do good. It deprives the many who have mentally ill relatives of the hope of escaping the same fate. It may bring about family interrelationships loaded with tension, brooding and gloominess which in itself may become the evil spirit that may precipitate a nervous breakdown.

In describing the aforementioned cases, I should like to divide them into three groups. The first one includes three cases where mental tainting and a disrupted family interrelationship form the background for the outbreak of the psychotic conditions.

GROUP A, CASE 1

Paternal grandfather was an alcoholic and described as "a little weak mentally." Paternal grandmother was said to have been insane and probably a case of manic-depressive psychosis of twenty-four years duration. A paternal grand-uncle was said to have "suffered from mania." A second cousin was reported to have been insane and to have committed suicide. Patient's mother and brother were both institutionalized several times with a diagnosis manic-depressive psychosis, depressive and manic types respectively. The mental tainting in this family is certainly a heavy one. In addition it was pointed out that

several members of the family were emotionally unstable, including the father of patient, although they never were institutionalized. The father is a well known man in his field, a university graduate and described as a circumstantial talker who always was vain, self-centered and oversolicitous with regard to work and family life. He gave minute details in every minor problem, frequently driving his family into despondency; he also discouraged his growing children continually by telling them that they never would achieve what he had accomplished.

The prepsychotic personality of patient's mother is presented as selfish, stubborn, worrisome and overattentive to her children. Yet their family interrelationship reveals an even more discouraging picture than their mental tainting. The married life of the two mates was uncongenial; the mother was harassed by financial problems and accused her husband of trying to get rid of her. The father was unable to hold a job for a long time and wandered from place to place, insisting that his family follow him wherever he worked. The two children were lacking not only the security of a stable home, but also of a systematic education by changing schools frequently and probably without having an opportunity to acquire friends and enjoy comradeship for a longer time.

Restlessness and flightiness are the predominant features of this patient, who was institutionalized many times and diagnosed as manic-depressive psychosis, manic type. Although sociable, intelligent and craving companionship, she is unable to keep up a long-lasting friendship. She has led a rather promiscuous sexual life; she is lacking any foresight in planning her future life, and shows a vague paranoid attitude toward her father, whom she accuses of having been the cause of their family trouble.

CASE 2

Patient's mother died at the age of 42 in a mental hospital. There is one paternal uncle at present hospitalized at a state hospital, and another paternal uncle died at the age of 50 in a mental institution.

Patient is the second-youngest child of five siblings. Two of her brothers became mentally ill at the age of 27 and 20 respectively. Both were diagnosed as hebephrenic schizophrenia, just as was their sister, the patient, who became institutionalized 16 and 12 years later than her brothers.

This is the story of their family life as told by the patient: "My father was a heavy drinker; he often was intoxicated and would beat up my mother. My mother was brought up very strictly; she was worrisome and oversensitive. Their married life was very unhappy, and my mother became insane when my youngest brother was about 4 and I was 6 years old. It seems that all the family trouble, my mother's illness and death, my father's poor drinking habits, have affected my two older brothers more than us three younger ones. It was quite a shock

to us when first my second-oldest brother, who was a friendly, sociable, kind-hearted fellow, became depressed, had crying spells and had to be put into a mental hospital, where he still resides after two or three attempts to start life anew outside the hospital. It seems that my father at last came to his senses, but it was too late. My oldest brother, who was always shy, retiring and extremely sensitive, had to be hospitalized also. It practically broke my heart, but it hit my sister even harder. I had to talk her out of the idea that we all will become insane. We were both attractive girls; we both married and had children. She is normal, but she thinks she is not. I never thought of becoming insane yet; a rape attack broke me down."

The patient had infantile paralysis at the age of 4. Her one arm remained paretic and underdeveloped. The ideas of grandeur which she revealed poorly agreed with her physical incapacity. Contrary to the description of her father, she told big stories about him, and although she lived under marginal circumstances, she told of high personnages who visited her and wanted to marry her. She even made of a poorly paid insurance clerk who attempted to rape her "a very well educated high official." Her delusions resemble very much the bombastic terms alcoholics frequently use as a compensatory reaction to their feelings of inefficiency.

CASE 3

The paternal family consists of four brothers and six sisters. They are of Slavic origin, but the father of patient has changed his name and had broken off contact with his family a long time ago. All members of his family were described as "high-strung and quick-tempered." One paternal aunt was hospitalized for many years and was said to have suffered from a persecution complex of a religious pattern. She died a few years ago. Another paternal sister was a resident of another state hospital and died of tuberculosis at the age of 40. She, too, was said to have suffered from a paranoid condition. The members of the maternal family were described as oversensitive, easily upset, and always under high tension. There was, however, no mental tainting in this family.

Patient is an only child, who received a college education and acquired a B.S. degree, in contrast to her parents who have a poor educational background. The father is more than 10 years younger than the mother, who in addition looks much older than her chronological age. She is an "old-fashioned home woman, a poor housekeeper, and a poor cook." She never showed any interest in adapting herself and their home and family life to her growing daughter's longing for a higher standard of living. She is described as extremely nervous, worrisome, stubborn, and resentful toward husband and daughter.

The father was very thrifty and wanted his daughter to be likewise. He had no higher goal in life, no other interests than his job, his

newspaper, and his savings. He was moody and at times had temper-tantrums. There was no link between him and his family, and he did not seem to have friends. According to information, the patient and her parents lived together in a small apartment, and even after the patient had grown up the parents still treated her as the dependent youngster she once was. As time went on these three people got on each others nerves, devoid as they were of any other companionship and interests outside their home.

The predominant features of this patient's prepsychotic personality were a complete lack of social interest, conceit, extreme ambition and tempers just as her father had. Although, according to her diagnosis, she suffered from schizophrenia for quite a few years, she had a well retained personality, and her behavior did not show signs of regression frequently found in the chronic stage of this psychotic condition. Stubbornness and aggressiveness, undue sensitivity and a quick temper, greediness combined with an unimpaired mental efficiency above average were her personality traits after more than two years of hospitalization. She seemed to be a perfect mixture of her father's and mother's emotional qualities, surpassing them in her mental make-up.

The three cases described have shown a more or less heavy mental tainting in their ancestral lines. Case 1 had a somewhat insidious onset, inasmuch as signs of strange behavior and pathological trends were manifested many months before the patient became uncontrollable and had to be institutionalized. Case 2 and 3, however, showed a rather sudden and unexpected onset, the former revealing the first signs of psychotic behavior soon after a rape attempt, the latter after the suicide of a woman working at the same office as the patient. The first patient was institutionalized in her earlier twenties, the two latter cases in their late twenties and early thirties, respectively. In all three cases, a home atmosphere full of interpersonal strife and tension, overshadowed by the threat of psychotic inheritance, characterize their family interrelationship.

Besides, the first three cases, I want to present three more where mental tainting did not involve the *ancestral* generation but the *siblings* of the patients. According to information obtained, no mental tainting could be found in the previous lineage. The family history, however, reveals a similar discordant and inharmonious contact as found in the cases of the first group.

We meet again the unbalanced parents, with their inability to provide proper guidance and support to their growing children, being too much concerned with their own petty problems and controversial matters. The emotional instability and mental insecurity which surrounds the children during their formative years are apparently felt more by the older ones and the siblings at the end of the line. The older ones are burdened with a responsibility they are unprepared to shoulder;

the younger ones are not yet able to exchange the lack of family interrelationship for any link outside their homes from which they might derive inner satisfaction.

The oldest sister of one of the patients put it like this: "We all were hard hit by the complete lack of family accord, the constant nagging of mother and the violent outbursts of father. I do not know why I was spared, although my sister and my brother next to me had to be institutionalized. I had to take care of the younger ones, and I lived in constant fear it might happen to one of them. I forgot about myself, seeing my second-youngest sister, the one who was least linked to us, becoming more and more emotionally unstable, erratic, and imbalanced. She who always had tried to negate her family seemed to reflect all the unlucky parental traits which made our family life so miserable."

GROUP B, CASE 1

The patient, who is at present 33 years old, was hospitalized for the first time at the age of 31, although there was an episode of depression about five years ago, which she overcame rather quickly without having to be institutionalized. She is the second-youngest of eight siblings. One sister, the second-oldest, was hospitalized with a diagnosis of manic-depressive psychosis, mixed type, for about a year and died a few years later. A brother, the third-oldest sibling and the oldest brother, was hospitalized when about 25 and is still a resident of a mental institution. His diagnosis is manic-depressive psychosis, manic type.

Patient's parents are described as "tempermental and high-strung"; their married life was an unhappy one, because of incompatibility and constant financial difficulties. The children did not get much attention on the part of their parents "who mainly were concerned with their own problems." The family life was always very tense and unhappy, and the children were left on their own without adequate guidance and training. Patient was in her early teens when her sister and later on her brother were hospitalized. She did not seem to be much concerned about it, but frequently mentioned it when she herself became mentally ill.

Patient was always strong-willed, easily dissatisfied, self-centered, stubborn and egotistical. She mixed only with certain people and very early broke away from her family and insisted in living her own life. She was an excellent student and managed to go to college for two years; she had always held good positions and seemed to get along fairly well. For about eight years she had a serious love affair with a married man whom she wanted to marry after his divorce from his wife. Yet, this dream of hers never seemed to materialize, and in an act of despair she married another man eight years her junior and a moron (as she discovered only after she had married him) after a frantic and short courtship. In the meantime, the other man obtained a divorce and married another girl. This brought about patient's

breakdown and hospitalization. She was in a state of depression, was greatly inhibited, lost initiative and concentration, improved and started working again. It was during this remission that she met her former friend again and, although he was remarried, she seemed to have indulged once more in her dream of marrying him. It brought about a manic attack and her present hospitalization.

She insisted she was pregnant by her friend of long years, although she was not. She heard musical voices performing for her Brahms, Haydn, Wagner, (her former friend was a musician). She painted crosses on the walls and insisted she was a gentile because the voices told her so (actually she was a Jewess). Her sister stated, "she always wanted to have a home of her own, a husband and children. In contrast to our mother she was an excellent house-keeper, economical, and an efficient and fast worker. However, it was difficult to get along with her, and although she broke away from our family and resented being a Jewess, she was the one among us who mirrored more than all the others our parents' unhappy character traits—their stubbornness, their egocentricity, their inability to conform their lives to those of others. In her hour of despair she did not have any friends and had to turn to us whom she had brushed aside especially because of her love for her friend, who was a gentile and who jilted her after having been with her for eight years. I am inclined to blame her upbringing, her poor training as a child, for her emotional instability, her poor judgement and her quick temper, in spite of the smartness and skillfulness she always displayed."

Stories of unhappy love affairs are frequently pointed out by relatives as the cause of a psychotic episode. Even if we may not agree with this etiological concept, we may assume that love affairs, dramatized to an unhappy end, reveal ill training and poor preparation of the young individual to the task of choosing an adequate mate.

CASE 2

The 21-year-old patient is the elder of two. She has a brother one year her junior. He was inducted into the marines, did well during his training, but had to be sent back from overseas before he saw action. He started to brood about religious problems, became afraid of people, was hospitalized and recovered.

The father of patient became a heavy drinker during the early years of his married life. He was indifferent and did not seem to be much interested in the welfare of his children. The mother met him when she was 18 and they married after a very short courtship. She is described as crying easily, nervous, and worrisome. She supported the family for many years, because the father was a poor provider. There were continual arguments and fights; the father went into a saloon, the mother became infatuated with another man, the children were left on their own and at last boarded out when the parents separated. At this

time the children were around 7 and 6, respectively. They were very unhappy at the boarding place, where they became thoroughly familiar with the promiscuous sex life of their mother. A short time later the patient went to live with her mother, the boy with the father. During the time the patient stayed with her mother the latter changed her friends frequently without being married to one of them. As she grew older, the patient became increasingly aware of this fact and "it hurt her very much." She became more and more unable to concentrate on her schoolwork, slipped into daydreaming, thought of becoming an actress, a poetess and an author, and failed in school. It seems that she became infatuated with one of the men her mother lived with and that for this reason the latter brought her to her father at the age of 18. She was deeply ashamed of her parents' way of life and started to hate the small town in which her father lived and where everyone seemed to know about their unhappy family life. She decided to go to New York and to live on her own. She had several odd jobs, was frequently in financial difficulties and fell under the influence of her brother, brooding with him about religious scruples. They discussed them and their unhappy family relationship. Then, she said, "I started to feel sorry for myself. I felt that I would never overcome my shyness and self-consciousness. I had no friends, no relatives. I did not even know where and with whom my mother lived."

After three years of a brave struggle with loneliness, economic worries, and brooding, she started to hear voices "which made me at first sad and then afraid and at last told me to become a nun. I became more and more unsure of myself, felt that I could not trust myself any more, could neither concentrate nor differentiate between right and wrong. I read a great deal about my condition, and it seemed to me that I was either a victim of telepathy and hypnotism or that I was suffering from schizophrenia." She was diagnosed schizophrenic. It took a long time until her father came to see her. He had not known her and her brother's whereabouts during the past three years. It seems that she was ashamed of her family's indifference to each other, because his visit relieved her greatly. After his first visit she wrote him a letter, the first one since her hospitalization, ending it with the following lines, "I would very much indeed like to see you—very soon again. Will you please write right away—and often, often??"

This patient was longing for companionship, yet she was unable to approach others, because she had never learned to do it in an inconspicuous way. She had never been trained to join others in the relaxing and joyful manner which makes for friendship and comradeship. She claimed "the only thing which always made me afraid is what people think of me. It is fear, simple fear that things may not turn out as I wish they would; that people will not appreciate and approve of me. I have no courage, no confidence in myself; that is my illness."

Case 3

The 17-year-old male patient is the fourth child of a very emotional mother who was described as temperamental and very religious. The maternal grandmother was said to have been eccentric and a religious fanatic. One maternal aunt was nervous and very much disliked by her family. It was she who frequently told the patient that he was the cause of his mother's death. None, however, of the maternal family was ever mentally ill or hospitalized. Nothing special is said about the father's family.

Patient has two older sisters, the first one, very close to the patient, was described as temperamental and sensitive. It was said that she married to escape an unharmonious home life. The second one, a graduate nurse, was described as emotionally stable and the mediator in the family. She was away from home for many years. His only brother, two years his senior, is described as clever, resourceful, and intelligent. He was under psychiatric care at the age of 14, because of fits of rage and temper. He recovered after living with foster parents for half a year and is at present attending a naval school, where he is well adjusted although at times moody.

Patient's birth was premature; he was a seven-months' child, because of his mother's illness; she developed pneumonia and expired soon after birth. He was kept in an incubator for three months and was removed to a children's village. He was and remained a feeding problem. His development was retarded; he started to talk at the age of 3 and to walk at 4. After his father's remarriage he was taken home at the age of about 3, where he received his share of attention at first. Later on it seems as if the stepmother favored her own children to the extent of preparing special food for them.

His prepsychotic personality was described as seclusive, sensitive, and keenly aware of the family conflicts. He expressed feelings of inferiority and showed lack of self-confidence. He had a desire to accomplish something worthwhile, which became more marked a few weeks prior to his hospitalization. He gradually became more seclusive, expressed grievances against his family, especially his stepmother, talked in a monosyllabic way, expressed fears of harming someone of his family, and stated that a power forced him to crush his glasses, which were at his bedside. After hospitalization, paranoid auditory and visual hallucinations followed, and he said about a suicidal attempt, "I became disgusted with everything that happened." He remained polite, manneristic, at times panic-stricken, and was diagnosed as a schizophrenic reaction type.

This patient, who was always pessimistic and undemonstrative, was exposed to the numerous family conflicts, of which he became painfully aware at a very early age. He received little understanding and com-

panionship and was markedly influenced by the moods of his surroundings.

The last group of patients, represented by the following three cases, reveal no mental tainting whatever. At least two ancestral generations and their collateral lines are free from mental tainting. If we do not want to diagnose incongruous family relations as manifestations of the imbalanced members, then we have to accept the rather broadminded statement of Abraham Meyerson,[7] who writes that "since mental diseases are amongst the most common afflictions of man, and the mind is probably the most easily disturbed of all human functions, whatever family group is studied long and intensively enough shows mental disease, and its denial means little or nothing. There are no negative family histories so far as mental disease is concerned, if one includes in the term 'family' three uncles and first and second cousins. Schizophrenia, manic-depressive psychosis, and kindred states occur in a sprinkle everywhere. In some unfortunate families the sprinkle changes to a shower, and we then speak of heredity."

If this statement is true, then we have to include in the families with mental tainting practically all families, for every blood-related group includes individuals of a peculiar pattern in a progressive or regressive sense. It means that family interrelationship does not play any role in the upbringing of young individuals. Mental hygienists, however, point to the fact that mutual understanding in family interrelationship provides an adequate surrounding to prevent the development of nervous and mental disease in children. A biologist, a psychologist and a geneticist[8] have recently studied a group of one-egg twins who were reared together and another group who were reared apart. The results show that the latter group deviated from each other in many ways that are related to their different environments, and that their differences in their respective I. Q. were, for instance, greater, than those of fraternal twins reared together.

This last group of patients hail from families where no mental tainting could be found. Yet we encounter in each case a similar family interrelationship as in the previous cases. The atmosphere in which they grew up is loaded with interpersonal strife of the parents, a lack of social interest, and a lack of benevolent cooperation.

GROUP C, CASE 1

The 21-year-old female patient became agitated, nervous, irritable, and fearful eight days after her marriage. During the first sexual intercourse with her husband she became hysterical and developed the idea that she had been seriously hurt. Later on she complained that her throat was broken, that she could not swallow, that she had lost her voice and thought she would suffocate. She "felt like dying," complained of breathing difficulties and became convinced that she had "gangrene of her brain." She lost interest, became considerably slowed

down, became restless and sleepless and at last refused to leave the bed or to take food, whining and crying all the time, until hospitalization was advised. A diagnosis of schizophrenia was made.

The patient is the elder of two, having one younger sister who is "more independent and rough." She was always a poor eater, spoiled by her mother and, although she was somewhat delicate, she never was sick in her life. She was said to have always been "an inward type," kept everything to herself and had an inferiority complex. She never stayed on a job very long and mostly gave as an excuse "that she could not compete with the other girls."

The mother ran the family, in particular the husband and the patient, whereas the younger girl succeeded "in getting out of her hands." The patient was very attached to her mother, but it was mere helplessness that made her cling to her, not real devotion. She simply could not get along when thrown on her own, and even when she was grown up the mother used to dress and feed her.

Both parents used to drink to excess and when in high spirit used to argue and fight a great deal. The patient feared these episodes, became extremely scared and used to go to bed, covering herself up from tip to toe in order not to hear her parents' quarreling. She slept with her mother in one bed up to her marriage. They arose irregularly, meals were not served regularly, and the mother used to accompany her to work. The mother refused stubbornly to consult a doctor when the patient did not feel well and always insisted "she knew better."

Both parents are said to have started drinking to excess after their children were born. They both were people of a rather primitive background, with many erroneous beliefs and disbeliefs and a faulty attitude toward life. Their living together was disorganized and unharmonious; the link between the family members was based on domination and insistence. They did not have friends or friendly relations with their neighbors, and there was a complete lack of guidance on the part of the parents. Patient's prepsychotic personality was characterized by fearfulness and sensitivity, extreme shyness, self-consciousness and an inferiority complex; she never made a decision of her own. It was always done by her mother for her.

CASE 2

A young man in his middle thirties, with a college education, started to suffer from a paranoid condition quite unexpectedly. A suicide attempt brought him to the hospital. He was married, had two children and a good position, and as his mother put it, "we would have expected everything but this terrible blow." His early youth and development were uneventful, except for one convulsion in babyhood. He was an ardent sportsman until he married, excelled in swimming and enjoyed especially outdoor life.

The family life was not a happy one. Patient has one sister, and

both realized rather early that "if they did not look at their family life sensibly they soon would become involved in the trouble." Patient's father insisted in having his own way and enforced his demands by violent tempers. He considered what he had to do "the most important thing in the world," was fussy about petty things and as he grew older he "acted more and more as a spoiled child." He believed in strapping the children, and punished them severely for little offenses. This was especially true for the boy, who as he grew older started to rebel against it. He soon developed the same violent temper as his father had, and "the damage was already done before the boy even went to school."

The mother was lacking completely in understanding, although she worried and fussed about the children so that she "nearly drove them crazy." She failed to stimulate and encourage the children, was bossy and tactless. She frequently caused the growing boy to get up and leave the house. Worst of all, this mother did not have any sense of humor, and she was unable to bear the responsibility during the years of schooling and education.

The parents never have gotten along, and "this did not make for a happy, normal home life." There was constant discord, and the parents were mainly concerned with their own petty arguments and struggles. Yet, both parents meant well with their children and tried to give them a higher education than they themselves had achieved. They worried a great deal about them, deprived them, however, of the most important factor of a normal childhood development, a concordant family interrelationship.

The boy had a mind of his own and soon did not listen to any parental suggestions. He gradually grew away from his parents, and his homecoming usually ended in a quarrel. In grammar and high school he had many encounters with his teachers, but never failed in his studies. He was irritable and impatient, sensitive and tempered. Little things seemed to bother him, but he was a hard worker and although he saw his father's faults clearly and resented them, he behaved much in the same manner.

He longed for a happy family life, a home and children. As soon as he had obtained a good position with a satisfactory income he married and seemed to be contented and happy. His married life was a congenial one, although his wife was frequently ill and two children were born in a relatively short time. He worked hard on his job, doing excellent and efficient work, and also helped his wife with the house and the children. Thus he was under quite a strain when he suddenly developed ideas of reference and persecution and started to hallucinate actively. He showed blocking and emotional bluntness and soon afterwards attempted suicide.

Both parents are still living, and although they still show personality traits similar to the ones mentioned they are well and active. This is

also true of his sister. More than the latter, the patient was subjected from his earliest childhood to the harshness of an ill-balanced father and a strict, worrisome and irritable mother. He was constantly exposed to the quarrels and arguments which seemed to have been the only way his parents knew to settle their problems. No wonder that this boy never learned another way of interrelationship until he had already developed the one which was least fitted to community living.

CASE 3

This patient, an 18-year-old negro girl, manifested signs of a schizophrenic condition after she was fired from her first full-time job. She had stayed on this job for a few months and seemed to have done well. It might be, however, that she was too young and inexperienced, so that her work was not as satisfactory as she thought it to be. She had tried hard because she wanted to earn her own living, having felt from earliest childhood the shortcomings of her existence more deeply. She did not know her father, had never known a real family life.

The patient is an illegitimate child. The mother never wanted to admit this fact, but the patient never has known her father, who apparently married another woman after the patient and a younger sister were born. The mother worked in the domestic field and lived with her little daughter in her employers' homes. In one of these positions the patient, at this time a baby, broke a precious vase, and from this time on the mother locked the child up in her small room, sometimes as late as 1 o'clock in the afternoon, until she had finished the lunch dishes. At the age of 3 the child spoke only a few words, of which the most frequently repeated was, "she bad girl," which she picked up rather quickly, because her mother greeted her like that when she found the bedding torn from the crib or when the child was wet. The word "wet" she also would repeat frantically, even when she was not wet at all. Her mother strapped her frequently, so that the neighbors could hear it through the partition.

The child never was taken out into sunny parks until a neighbor took her out frequently when shopping. From this time on the girl developed better and faster, learned to speak and to control her bladder. Her first playmate was a little white girl, who seemed to have taken a liking to the negro girl until the former came one day explaining to the patient's mother that "my mammy doesn't want me to play with colored girls." She never showed up again, and the patient called in vain for her little playmate.

At this time patient already had developed extreme fear of her mother, who, though she meant it well, apparently had neither the instinctive nor the comprehensive capability of bringing up children. It seems that even at this early time there was a general belief that the child was difficult, for when the mother applied once for a position, the clerk at the employment office said right in front of the child "that it

was difficult to get the mother a position because of her 'very bad girl'." Later the mother secured a position on an isolated country estate, where the child was completely deprived of the company of other youngsters. After her mother lost the job, the girl was taken to a home for colored children, where she often was found alone in a bare room.

A short time later she landed in an orphanage home, where she stayed until the age of 7. It was then that she was taken to the home of her foster parents, to whom she became deeply devoted. She was described by them as obedient, ambitious and very understanding. She grew tall, and her schoolmates used to tease her and to call her "ugly blackie." This dragged her down and hurt her very much. She began to dislike the other youngsters and withdrew more and more from their company.

She improved in her studies, and her reports showed grades between 80 and 90. She became an honor student in the Spanish language and decided to become a trained nurse after graduating from high school. However, the case worker told her that she would have to start working, and the patient took up vacation and part-time jobs. She could not keep up with her studies and decided to take up a full-time job and to finish up high school in night classes. At this time she started to complain to her foster mother that the boys and girls in school called her "nigger" and "black bastard." The foster mother could never find out if this was true or already imagination, but was inclined to think it could have happened, because of the widespread race discrimination of which she had heard in this particular area.

In her hallucinations she heard people calling her "nigger, black bastard, and blackie." In her delusion she found herself married to a Jewish boy, and she insisted that she was not a colored girl, but a Jewess. After recovery she turned out to be an excellent ward worker, and although she was still shy and seclusive, she was very intelligent, keenly interested in reading and studying.

In the case of this patient, the complete lack of understanding and guidance during the forming years of her earliest youth resulted in a reticent personality, with self-consciousness and oversensitivity its prevalent features. Not even the relatively happy home which she found with her foster parents from the age of 7 could make the memories of frustration fade out completely. She became increasingly aware of the fact that she was not only a negro, but an illegitimate child, a "bastard without a family to belong to." Her striving to become self-reliant, which would have enabled her to continue her study, was crossed by losing her first job under conditions which hurt and discouraged her greatly. There were no home, no family, no friends to whom to turn for comfort and support.

The case records presented are only a few of the many in which patients show psychotic manifestations with or without mental tainting

and who have in common a history which reveals a family interrelationship unsuitable to an adequate development and adjustment of young individuals. We are at present unable to point to one factor with certainty, which may bring about the specific reaction type characteristic of the functional psychoses. We do, however, know of the damaging influence of faulty training as a cause of maladjustment, which we may tentatively call a precipitating factor of neurotic and psychotic conditions. Joseph Perlson,[9] in saying that there is no convincing evidence of the direct hereditary transmission of schizophrenia quotes Essen-Moller who maintains, "that by complete sterilization of all schizophrenics, the time necessary to reduce their number to 10 per cent of the present figure would be twelve hundred years." He then adds, "that the development of schizophrenia in an individual from a family of neurotics is probably due as much to faulty training as to poor heredity." Even the most carefully executed eugenic measures will not prevent the appearance of mental disorders, since according to Franz Kallman,[10] a greater number of carriers of the predisposition of schizophrenia is covered by the manifestations of psychopathy, feeblemindedness, or alcoholism than by the concept of the so-called normalcy." Well-balanced parents' personalities, a harmonious family accord, an interrelationship which may prevent the development of the "shut-in" personality, linking the young individual to people outside his family circle at an early age, activity connected with the joy of being constructively busy and an educational method of encouragement may help to avoid the rise of tension, agitation, fear, and feelings of inadequacy as the predominant features of prepsychotic personalities.

The parents' relationship is of utmost importance for their children's emotional development; their bearing and attitude toward the tasks of life are the blueprints of their offsprings' mental and emotional pattern. We have to bear in mind that the thinking process is a function of an organ, the brain, and to speak with Adolph Meyer,[11] "mind like every other function can demoralize and undermine itself and its organ and the entire biological economy." We know that poorly functioning organs can be trained and reconditioned, and this refers as well to the brain itself as to the nerve trunk and nerve fiber and any other organ. The difference obviously lies within the quality and quantity of training applied.

We cannot expect mentally and emotionally well balanced children brought up by tense and easily agitated parents. We cannot expect the young individuals to reveal initiative and spontaneity, when their educators don't stimulate these qualities and, on the contrary, prevent the individuals from displaying them. The personal influence from an emotional, ill balanced parent, and in this group are to be included the alcoholics as well as the ill tempered, the agitated and the worrisome types, may have the more deleterious influence upon the growing child's

future conduct if the young individual is deprived of the link with others. In ninety consecutive cases of psychotic patients with paranoid trends I found the following character traits prevalent in their parents and closest relatives:

Character Trait	No. of cases	Percentage
Shyness	58	64.4
Self-consciousness	65	72.2
Feelings of inferiority	72	80.0
Sensitivity	76	84.4

Parents and relatives claimed that these qualities made them unfit to mingle freely with others and kept them from living a normal family life. The patients' prepsychotic personalities showed predominantly similar character traits, only more marked and distinct.

No individual can attain maturity without constant interrelationship. When we look at our patients from this angle we may be able to understand better their withdrawing trends, their inability to approach others appropriately, their distrustful attitude and, as a rather logical consequence, the development of ideas of reference and persecution. Any individual who did not find stability and security in his family interrelationship will have to make more and increased efforts in his intersocial relations. Many will fail in this endeavor and may spend their energy in fruitless and unconstructive attempts to gain acceptance and stability.

The cases I have presented reveal most frequently an interparental relationship marked by uncongenial approach and lack of unity. A nagging and worrisome mother, a tempered and rigid father do not make for good educators. They may set a reaction pattern, which may prevail in the growing child who did not have an opportunity to know other behavior patterns.[12] We meet this type of parents in eight out of nine cases presented. The parent-child and the child-parent relationship is usually indicative of the parental interrelationship. As a potential factor in precipitating psychotic conditions, therefore, family interrelationship is as much a psychiatric problem as is inheritance, constitution and disposition.

SUMMARY

1. Case histories of three groups of patients are presented where a discordant family interrelationship loaded with tension and interpersonal strife, in two of the groups combined with more or less heavy mental tainting, in the last group without apparent hereditary factors, form the background for the outbreak of the psychotic condition.
2. In all of these cases the patients were exposed to an entirely inadequate reaction mode of unbalanced, hyperemotional, ill-tempered and worrisome parents who thus deprived their children of the sense of security imperatively required during their phase of immaturity.

3. It is evident that a healthy mental and emotional development can only be secured by interfamilial harmony. An inconsistent and disharmonious family interrelationship seems, if not an etiological factor in itself, to be a precipitating factor in the development of psychotic conditions.

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