CHILDHOOD SCHIZOPHRENIA

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3. SCHIZOPHRENIA AS A REACTION TO EXTREME SITUATIONS*

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GIVEN the limitations of space, and the very complex problems presented by childhood schizophrenia, the following remarks are suggestive rather than exhaustive. Sidestepping the question of whether, and to what degree, childhood schizophrenia is organic in origin, an issue that I do not feel competent to discuss, I shall restrict my remarks to considerations based on the premise that the functional aspects of this disturbance are, in and by themselves, sufficiently important to warrant extensive study, even if we cannot be quite sure that we are dealing with an entirely functional disturbance.

The comments presented here are derived from observations made in 24-hour-a-day living, over a period of years, with a number of schizophrenic children at the Orthogenic School. Paralleling the experiences others have had in other institutions, we have succeeded in rehabilitating quite a few schizophrenic children—though unfortunately by no means all of those with whom we have worked—through providing them with a therapeutic living situation, treatment and education all based on psychoanalytic principles. As long as those who hold the view that schizophrenia is organic in nature do not present us with methods of therapy that are more successful than those based on psychoanalysis, it is justified if, for the time being, we neglect the organic factor, about which we can do nothing as yet, and concentrate instead on that psychological understanding and treatment which yields some quite worth-while results.

With this introduction, I should like to address myself here to the questions of 1) the psychological origin of childhood schizophrenia in parental, particularly maternal, attitudes; 2) its nature as an autonomous reaction to the nonspecific trauma of feeling subject to an extreme situation; 3) the reasons for the skepticism about cure; and 4) the treatment required.

In some psychoanalytic discussions, childhood schizophrenia has been viewed as the consequence of parental—particularly maternal—attitudes, occasionally so much so that reconstructions and study of the assumed cause of the disturbance—the mother—seem to have taken the place of the study of the disease itself. Direct connections have been established between

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maternal attitudes—about which relatively much was known, and which were easy to study—and the behavior of the schizophrenic child, about which little was known and which was difficult to understand. This may have been partly because it is possible to gain fairly adequate information from a relatively well-functioning parent who at least talks, compared with what can be gleaned from an autistic child.

Some studies seem to view the schizophrenic child, or at least his pathology, as not much more than a negligible appendage of maternal pathology. Though never explicitly stated, such an attitude has led some students of this disturbance to concentrate mainly on the mother, not only for understanding, but also for helping, the schizophrenic child. Thus the child, who suffers most of all from not having acquired an autonomous existence as a person, is again not regarded as an autonomous being even in treatment efforts designed to help him become a human being in his own right. As if in culmination of an all-too-subtle irony, treatment methods are advocated which rely on efforts to understand and help the schizophrenic child through the very person who, it is assumed, destroyed his humanity in the first place—his mother.

Because of the infant's total dependency on the mothering person, because of his inability to take care of himself physiologically, he is also viewed as totally dependent on the mother's psychology. Actually, the infant is by no means simply a *tabula rasa*. From birth on, his psychological reactions are shaped by, but also shape, his mother's relation to him, as Escalona has pointed out in discussing atypical children (6). Severe as the impact of the mother may be, the child also responds all along in terms of his nature, his personality. Just because it is so extraordinarily important for the infant's present well-being and later healthy development to have a good mother, it is erroneously assumed that any mother-child relationship is so valuable that it must be salvaged, even when it is damaging to the child. Hence, efforts are made to treat mother and child simultaneously. It has been our experience that this works only when their disturbances are relatively mild.

> A mother whose schizophrenic child lived at the School had been in prolonged psychoanalytic treatment. She was making good progress, but we felt that her influence on her child was so pernicious that they should remain separated. The mother's analyst thought that the mother needed to test her ability to be a better mother, and supported her in her insistence on a home visit. Reluctantly, we agreed to a visit of two weeks' duration. The child set fire to the parental bedroom while the parents were asleep there. No great damage was done and the parents viewed this as a childish prank. A year later, with the approval of her analyst, the mother again insisted on a visit. We were opposed, because the child, who was functioning very well within the protected setting of the School, expressed great fear about what might happen on such a visit. Despite our objection the visit took place; then, while with his parents, the child died in a carefully contrived accident.

True, this is the worst tragedy that has befallen a schizophrenic child with whom we have worked. But there are many parallel observations. One of Dr. Mahler's examples may illustrate:

> Within the benign and constructive setting of the treatment room, a little girl greatly enjoyed playing with a flashlight her analyst had given her. Driving home in the car with her mother from the analyst's office, the girl put the car's hot cigarette lighter to her mouth, causing severe scorching of her lips (11). The presence of the mother had changed a pleasurable experience into a destructive one.

Trying to rehabilitate such children while they continue to live at home thus becomes a questionable procedure. Given the prevailing ambulatory treatment of schizophrenic children while they live with their parents, one can readily understand why Dr. Mahler, and others, arrived at the conviction that "the outlook as to real cure is bleak" (11). But this skepticism is derived from, and valid only for, the ambulatory treatment of autistic children; it is contradicted by our experience with institutional treatment. Unfortunately, this pessimism has been extended from a particular treatment method to the disease itself.

If we treated schizophrenic children mainly by seeing them for an hour a day in an office, or if we worked with them in a hospital for only a relatively short time, we, too, would be pessimistic about the course of the disease under psychotherapy. One wonders why more workers have not arrived at the only possible conclusion, namely, that since the most frequently used treatment does not work satisfactorily, a different method must be applied which is feasible and seems to yield much better results. This, incidentally, was suggested by Dr. Kanner quite some time ago, when he advised that autistic children should be placed outside the home with some warm, understanding persons (9, p. 728). I should like to add that the setting in which such treatment will be most successful—at least so far as the present state of knowledge permits us to say—must meet certain other specific requirements, some of which I shall mention later.

All this would be quite easy to see if we would just listen carefully to what the schizophrenic children tell us, at least those who talk. They will let us know readily enough what kind of treatment they need—which is another example of the fact that only through thorough study and treatment of the child—and not his mother—will we make progress in understanding and helping him.

In order not to be accused of presenting biased findings on this most important problem of how the schizophrenic child should be treated—after all, what the children at the Orthogenic School tell us might be influenced by our convictions about their treatment needs—I shall instead quote one author beyond reproach. Anna Freud, speaking about a schizophrenic, adolescent girl, reports:

> After several months of struggles in the treatment, during which relations to the analyst went up and down, wavered, threatened to dissolve, to peter out, to extend to other figures in the environment in turn, the girl said to the therapist: "You analyze me all wrong. I know what you should do; you should be with me the whole day, because I am a completely different person when I am here with you, when I am in school, and when I am home with my foster family. How can you know me if you do not see me in all these places? There is not one me, there are three."

Here, then, we are given the essence of what must form the treatment of the schizophrenic child. Unfortunately, Anna Freud does not reflect on the merit of this treatment recommendation, but continues:

> It struck me that here, disguised as a piece of "technical advice," we were offered some insight into the basic deficiencies of her ego structure. There had been, in her past, no opportunity to introject any one object sufficiently to build up inner harmony and synthesis under the guidance of a higher agency, acting as a unifying superego. Her personality shifted, following the promiscuity of her relationships. She was well able to adapt herself to the varying environments in which her life was spent, but in none of these relationships could she build up a real feeling of self, or correlate the self experienced in one setting with those of another setting. What she asked the therapist to do was, as it were, to offer herself in the flesh as the image of a steady, ever-present object, suitable for internalization, so that the patient's personality could be regrouped and unified around this image. Then, and only then, the girl felt, would there be a stable and truly individual center to her personality which she could transfer and offer for analysis. . . . We are faced with the technical question whether such preparatory assistance, if undertaken in all earnestness, would be compatible with later analytic work (7).

Here treatment requirements are clearly stated by the patient and recognized as valid by the analyst. But then, instead of arranging for treatment along these lines, the issue is dropped in favor of discussion of the problem whether, if such treatment is instituted, later analytic work will be possible. On the basis of many years of experience with exactly the type of therapy this girl requested, my answer is: given the treatment she asked for, she may not need a later analysis; not given this treatment, as likely as not, there will be no occasion for later analysis.

Schizophrenic children indeed need a therapist who " . . . offers herself in the flesh as . . . a steady, ever-present object . . . so that the patient's personality could be . . . unified around this image." From experience I can add that, after a few years with such a person, the child will relate and acquire a relatively stable and truly individual center for his personality; will be able to live fairly successfully with this personality; and will feel no need to transfer it, or offer it for analysis.

Returning to the problem of the origin of childhood schizophrenia, it can be said that the mother's pathology is often severe, and in many cases her behavior toward her child offers a fascinating example of an abnormal relation. But this proves neither that these mothers create the schizophrenic processes, nor that specifics of their pathologies explain those of the children. It seems that the concentration on the mother, or the mother-child

relation, is the consequence of an unrealistic ideal—that of the perfect infant-mother symbiosis, where both form a completely happy psychological monad. Perhaps because the myths of the happy primitive, and of the innocent infant, have been exploded, this other myth has taken their place. To escape the isolation of man in modern society, to do away with the anomy from which we suffer in reality, we have created the wish-fulfilling image of the perfect twosome, mother and infant. We have overlooked the fact that individuation, and with it stress and pain, begins at birth.

Fortunately, this is being recognized, and psychoanalysts now decry the haunting image of the rejecting mother. Again to quote Anna Freud:

> A mother may be experienced as rejecting by the infant for a multitude of different reasons, connected with either her conscious or unconscious attitudes, her bodily or mental defects, her physical presence or absence, her unavoidable libidinal preoccupations, her aggressions, her anxieties, etc. The disappointments and frustrations which are inseparable from the mother-child relationship [must be] emphasized. The mother is merely the representative and symbol of inevitable frustration in the oral phase. To put the blame for the infantile neurosis on the mother's shortcomings in the oral phase is no more than a facile and misleading generalization. . . . The mother is not responsible for the child's neurosis, even if she causes "chaotic" development in some instances. By rejecting and seducing she can influence, distort and determine development, but she cannot produce either neurosis or psychosis. I believe we ought to view the influence of the mother in this respect against the background of the spontaneous developmental forces which are active in the child (8).

If, then, childhood psychosis is due to spontaneous, developmental forces in the child, what experiences set the psychotic process going? Observing the mortal anxiety which regularly underlies the symptomatology of these children, I was, for a time, very much taken by Dr. Pious's views on the role of mortido in schizophrenia (12). But his views did not fully agree with our observations. Then in my ruminations, checking ideas against observations, it occurred to me that once before I had not only witnessed, but had also partly described, the whole gamut of autistic and schizophrenic reactions—not in children, but in adults. And these reactions, totally different from person to person, were all responses to one and the same psychological situation: finding oneself totally overpowered. What characterized this situation was its deep impact on the individual, for which he was totally unprepared; its inescapability; the expectation that it would last for an undetermined period, potentially a lifetime; that, throughout its entirety, one's very life would be in jeopardy at every moment; and that one could do nothing to protect oneself.

This situation was so unique that I had to coin a new term: extreme situation. Since then, the pressure of world events has given this new concept wide reception. I am referring to my discussion of the impact of the German concentration camp on its prisoners, and of the far-reaching personality changes which are the consequence of having to live under extreme condi-

tions (1, 2, 3). I discussed, among other problems, the difference in response to extreme, and to suffering experiences. The latter were dealt with by one's normal—or, if you please, neurotic—personality. It was only the extreme experiences which led to radical changes in individual personality structures.

Though the conditions of living in a concentration camp were more or less the same for all prisoners, one could observe practically all types of schizophrenic adaptations and symptomatology—so much so, that a description of prisoner behavior would be tantamount to a catalogue of schizophrenic reactions. For example, some prisoners responded to living in an extreme situation with suicide, or suicidal tendencies, including the inability to eat. (This we may compare to infantile marasmus.) Others developed catatonia, responding to any demand of the Gestapo as if they had no will of their own, or had lost control over their bodies. Many went into melancholic depression, while others developed delusions of persecution way beyond the actual persecution they experienced. Illusions, delusions, and ideas of reference were frequent, as was megalomania. Superego and ego controls broke down, resulting in delinquent and criminal actions and regression to infantile behavior, including incontinency. Loss of memory was universal, as were shallow and inappropriate emotions. The great differences in schizophrenic symptomatology depended on the prisoners' personalities, life histories, socioeconomic background, etc., but the fact that they developed schizophrenic reactions was the specific result of being forced to live in an extreme situation.

The difference between the plight of prisoners in concentration camps, and the conditions which lead to autism and schizophrenia in children is, of course, that the child has never had a previous chance to develop much of a personality. The important parallel, on the other hand, is that the youngster who develops childhood schizophrenia seems to feel about himself and his life exactly as the concentration camp prisoner felt about his, namely, that he is totally at the mercy of irrational forces which are bent on using him for their goals, irrespective of his. Or, to put it in different terms, since the egos of these persons prove unable to give protection against the impact of reality; do not help preserve physical or emotional integrity; are unable to exercise their normal task of assessing reality correctly, or predicting the future with reasonable accuracy, thus making it impossible to take steps to influence it, such egos appear not worthy of investment with vital energy. As a consequence, the egos of persons living under such conditions become so divested of energy that they can no longer exercise influence and control over the other institutions of the mind, id and superego.

Returning from such theoretical speculations to reality, one must take cognizance of the many differences between life in a concentration camp and the life of a child who develops schizophrenia. Still, the emotional responses of prisoner and child to their very different conditions of life are strangely similar. There are, of course, differences, such as in intellectual and emotional maturity. Therefore, to develop childhood schizophrenia it is sufficient that the infant is convinced that his life is run by insensitive, irrational, and overwhelming powers, who, moreover, have total control over his life and death. For the normal adult to develop schizophreniclike reactions, this has actually to be true, as it was in the German concentration camps.

In our work with schizophrenic children, we found again and again that their schizophrenic symptomatology was not just a reaction to generalized attitudes of parents, such as rejection, neglect, or sudden changes in mood, but that, in addition, specific, and for each child different, events had created in the children the conviction that they were threatened by total destruction all of the time, and that no personal relations offered any relief. Thus, the psychological cause of childhood schizophrenia is the child's subjective feeling of living permanently in an extreme situation, that is, of being totally helpless in the face of threats to his very life, at the mercy of insensitive powers which are motivated only by their own incomprehensible whims, and of being deprived of any interpersonal, need-satisfying relationship. Three examples may serve to illustrate.

1. Parents considered their boy feebleminded from the moment he was born. Since he supposedly did not understand, they spoke freely of how he ought to be put away, how he should never have been born. Autistic withdrawal led to his being sent to an institution for feebleminded children, where he was badly neglected and where he was often deprived of meals as punishment. This added to his conviction that his parents wished to kill him through starvation. He spent most of his first seven years in phantasies of how he would torture and kill others before they could kill him. (Such phantasies were typical among concentration camp prisoners.)

2. Prolonged observation of a boy's behavior convinced us that his delusions of persecution and anaclitic depression were the consequence of a severe traumatization, possibly some dark and terrible secret, which may have taken place before his verbal abilities had fully developed, and which he therefore could not easily reproduce in any other form than that of vague but totally destructive images. Despite his parents' cooperation with our effort to establish a detailed early history, they were unable to provide any information about such a secret, nor could the boy himself recollect anything but death anxiety and overwhelming rage, which he had to repress totally.

Following the lead that this child clung frantically to his older brother, we eventually succeeded in having the latter shed light on the "killing secret." He told us that when the younger boy was not yet three years old, the older brother and some of his friends had played a hanging game with the boy as victim. The rope had cut off the child's breathing and he was only revived after artificial respiration had been applied. Dreading that the boy might tell, the older ones established a regime of terror. Repeatedly and severely they beat up this youngster, threatening even worse tortures if he should ever reveal the story. In order to make the threat more effective, they repeatedly locked him up in a dark and inaccessible excavation and kept him there for prolonged periods despite his terrified screaming. (It might be mentioned that, although this boy has been with us for some time, only anxious phantasies of being locked up in dark rooms have spontaneously come to light. The trauma of hanging has not been recovered so far.)

3. Before the age of three, chance observations led an adopted boy to guess his

mother's adulterous relations. During the year following his discovery, and although he did not fully understand what he had stumbled on at the time, the mother repeatedly threatened to kill him if he should ever tell anyone what she did in her relationship to the other man, or should even so much as mention his name. As the child grew older, he was threatened daily that he would be killed if he told anyone about the mother's affair. Then, before he was five, the mother deserted husband and son without warning. Our observations led us to feel that this boy stood under a dreadful fear for his life, that he was hiding a terrifying secret, the nature of which did not seem clear to him. Only through a former servant, who had been sent away from the home after the affair began, was it possible to learn in some detail about the early and repeated traumatization of the child. Subsequently, memories of these threats were spontaneously produced by the boy in play sessions.

So much about some of the psychological factors which seem to occur characteristically in childhood schizophrenia. What about its treatment? Skeptical about its cure, Dr. Mahler mentions the "insuperable plateau of arrested progress, which usually . . . frustrates the . . . hopes of the parents. Impatient reactions and pressures are then exercised and progress forced," but " . . . if the autistic child is forced too rapidly into social contact, and particularly if the newly formed symbiotic relationship causes frustration, he is often thrown into a catatonic state and then in [a] fulminant psychotic process" (11). But why should the psychotic child be treated under conditions where parents are permitted to expose him to their impatient pressure? Why should he be forced too rapidly into social contact, and why should the newly formed relationship cause frustration? It may cause frustration if, for example, it is restricted only to a few office hours, but then this would not be heeding the advice of the girl quoted by Anna Freud.

Dr. Kaplan, in his discussion at the 1953 Round Table on Childhood Schizophrenia, made the important points that the schizophrenic child needs most to live with a "need-satisfying" person, and that these children have tremendous difficulties in achieving socialization because of the inabilities of their egos to cope with instinctual drives and reality pressures (10). Thus, in treating the schizophrenic child, we must provide him with truly need-satisfying persons—and not just for one hour a day, but all day long, every day of the year. Further, he must be permitted to live in an environment that exercises no, or only minimal, pressures and is so comprehensive and simplified that it can be mastered even by the child's weak ego; an environment which tends to reduce libidinal pressures and in which it is safe for both the child and his environment if he acts them out. Actually, these requirements are complementary. The need-satisfying person, through the physiological, psychological, interpersonal satisfactions he provides for the child, reduces the pressures of his libidinal tendencies and anxieties; the absence of reality pressure in the environment in which they both live makes it possible for this person to remain need-satisfying, and permits the child eventually to recognize it. It must be an environment, for example, that

accepts symptoms as legitimate expressions of the child's needs or anxieties, and this, again, not just during the treatment hour, but all day and all night.[1]

I cannot spell out here how this is done; instead, one example may illustrate the way in which an 11-year-old autistic boy provided himself with those experiences he needed most.

In a first reaction to the freedom to live according to his needs, this boy, whose toilet training had never broken down before, stopped defecating. He retained his stools for over two weeks, thus asserting his autonomy over his bodily functions, contrary to maternal demands. Eventually he gave up withholding his stools, but would not use a toilet. For nearly six months, he soiled himself and played with his feces. But during this time he slowly emerged from the rigid, catatonic state in which he had been for years.

After he had thus convinced himself that in the environment of the School he possessed autonomy, at least as far as elimination was concerned, in about his fourth month with us he spontaneously provided himself with the experience of being fed, first, as it were, by himself, then by a mother figure. He began habitually to put his food into his mouth, mash it and mix it well with saliva, then spit it on to his sleeve, mess it there some more, and finally eat it from his arm. Thus, in a way, he fed himself from his own body. In a next step, he spat or put this mess, not on his own sleeve, but on that of his counselor. Convinced of his deep need to do so, his counselor, to quote her, accepted this "as part of the meal, like the salt and pepper. This putting on of food is done with great deliberation. He takes the food in his mouth, chews it, puts it in his hand, presses it into my clothes, looks at it, scrapes it off the clothes, and puts it back in his mouth and eats it. I usually wear a blue denim shirt and a jacket which I put on when we go for a meal. Then when we are through I can wipe the remnants of food off these clothes and keep them to wear to the next meal. I now feel quite comfortable about his putting food on me."

Though repeated at least three times a day at the regular meals, and often between meals, this is not yet a personal relation, but it is slowly growing into one. As the infant does not at first recognize his mother as a person, but may feel that he feeds himself, so this boy first fed himself from his sleeve. As the infant later recognizes that he is feeding from the mother's body, so the boy later fed from his counselor's sleeve. Even then, he probably did not recognize her as a person, but simply felt it more pleasant to feed from her than to feed from himself. His feeling may have been something like: "There's something out there which, when it lets me eat off her, makes eating feel good." Contrary to his past experience when everything that came from the outside was overpowering, threatening, and unpleasant, now something coming from the outside was subject to his control; the other person was overpowered by him; and what came from this person was pleasant. When this stage was reached, with some small encouragement, day wetting, soiling, and smearing with feces disappeared, to be replaced by a more active and aggressive cognizance of the environment. For example, he began to urinate deliberately on the bed of a boy whom he viewed as his main competitor for his counselor's undivided attention.

Thus, we may speculate that this boy began to unfreeze, after he could first assert his autonomy by not giving up feces, and then by ridding himself of them wherever and whenever he pleased. After such assertion of "anal"

[1] For a description of one example of such an environment, see Bettelheim (4, 5).

autonomy, he began to satisfy his "oral" autonomy by feeding from himself. The external world began to acquire meaning as he fed from a preferred object, and he began to master it as he asserted his phallic autonomy by urinating on undesirable objects. During this development, his incomprehensible talk in neologisms and his echolalia changed into understandable communication, and he began participating in simple, childlike games. This takes us to the present time, the end of this boy's first eight months with us.

It is easier to give an example of our procedures than to generalize about them, since they have to be geared to the chronological and emotional age of the child, his personality, and the nature of his disturbance and his symptoms. But the most important fact is that these children must live in a setting that is totally therapeutic. They need an institutional treatment in which a therapist does not treat a child for a few hours a week, but where the need-satisfying person lives with the child. The therapist must be that "steady, ever-present object, suitable for internalization" about which Anna Freud spoke. True, no one person can take care of such a child all day long. But if an infant has a good mother for many hours each day, then it matters little if one or two other persons share in her work. But this one, central person must live with the child, must be immediately available day and night. If this is so, her absence for hours at a stretch can be suffered without harmful consequences. If the schizophrenic child has learned—and in our school he learns it soon—that the room where his counselor lives is just a few doors down the corridor, if he sees her around many times during the day, then this availability permits him to forego her immediate presence, which he at first requires.

Basically, what such a child needs is a mother free of the emotional demands so many mothers make, so that he can benefit from mothering without having to respond to it, or so that he is free to respond in his own good time and his own schizophrenic way. Only thus can be begin to re-establish his autonomy.

But he must be able to recapture such autonomy not only in the treatment room, or in regard to his emotions. For him to begin life anew, the total, extreme situation which destroyed his autonomy must be replaced with a total living situation over which he can exercise control. As he was overwhelmed by his environment, he now must be able to control it, and to control it successfully. That means it must be simple; it must not offer complex challenges, nor make complicated demands. The need of such a child for sameness and his desire for simple routines have been stressed. Basically, he has to feel as safe, protected, and in command of his environment as the happy infant may feel in his cradle. We cannot put such a schizophrenic child in a cradle, not only because he is no longer an infant, but also because it would violate whatever feeling of self-respect he might have acquired,

deprive him of whatever negative autonomy he might have achieved through his symptoms, and restrict his freedom of movement and expression. But we do have to provide him with an environment that creates only those slight challenges and stimuli which are compatible with the utter security the infant knows in the crib. We must protect such a child against any hostility coming from the external world, most of all, from his parents; must provide maximum need-satisfaction; and demand hardly any socialization, so that the pressures of his impulses are reduced while the demands of the environment are cut down to a minimum.

When living under such conditions, even a very weak ego can begin to function more adequately. In practice, this certainly implies self-demand feeding of favorite foods, and this any time of day or night; no insistence on toilet training, or otherwise socialized behavior; no restrictions on motility unless they are clearly beneficial; opportunity for total rest whenever desired, etc. Given such indulgence, it is possible to put some limitations on the discharge of aggression as far as physical harm to others is concerned, and to limit those self-perpetuating, addictionlike preoccupations, sexual or otherwise, which drain too much vital energy or build up tension rather than reduce it. We must try to make it possible for the child to live according to his autonomous desires, always with the caution that such exercise of autonomy must not lead to hardship for the child, because otherwise his ego would prove once more inadequate. For example, we must provide all the necessary material for, and encourage the construction of, safety devices, and any contraptions which the child needs to feel secure.

Living in such a benign situation, the child may become ready to start life anew. Strangely enough, we have found that it takes a schizophrenic child about as many years to become ready to do this as it takes the normal child to develop his personality. It seems that, for the child to develop his personality, it requires two, three, or four years of living uninterruptedly in a physical and human environment that promotes autonomous personality growth. The same time and conditions are required for the schizophrenic child to develop his new personality. Then these children feel reborn, and they begin a new life of their own.

Here, again, there is a striking parallel to the experience of concentration camp prisoners. A dominant preoccupation of their daydreams was the idea that they would start an entirely new life after their release from camp. I cannot speak with authority, but a casual observation of these prisoners suggests that only those who managed really to begin, in a fashion, a new life after their release fully overcame the damaging influence of the camps. Being subjected to living in an extreme situation somehow contaminates permanently the old life, the old personality. I would like to speculate as to why this is so, but prefer to wait until more evidence is available. All I

may suggest is that a personality that did not protect the individual against landing in an extreme situation seems so deficient as to be in need of widespread restructuring.

Returning to childhood schizophrenia, I should like at least to mention that, much to our surprise, we have found that quite a number of schizophrenic children, at the crucial point in their rehabilitation when they are ready to reintegrate their personalities, also begin their new life symbolically; so much so, that they undergo again the experience of being born. Unfortunately, presentation of the evidence on this process of rebirth would transgress the limitations of space. One case illustrating both the severity of the extreme situation which led to a child's schizophrenic withdrawal, and the process of her symbolic rebirth was published recently (5, pp. 155–270). In ending this paper, I should like to quote what an autistic boy told his therapist—who, for years, had offered herself to him as a "steady, ever present object, suitable for internalization"—at the moment he was symbolically giving rebirth to himself. This rebirth he achieved through hatching from an egg laid by his imaginary companion and alter ego, whom he called "Chickenpox Hen." The boy said, "I hatched from an egg I myself laid. You know, that happens to very few people." Let us hope that, as we learn more about childhood schizophrenia and its treatment, more schizophrenic children will be offered such a chance to begin life anew, as it were, from the egg itself.

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