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THE CONCEPT OF EARLY MATERNAL ENVIRONMENT IN DIRECT PSYCHOANALYSIS

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INTRODUCTION

In the practice of direct psychoanalytic psychiatry, we have been looking for the origins of neurosis and psychosis. We have traced these origins, through the manifest behavior which we observe, to the individual's infantile experiences with his mother. From there, our attention has been drawn to the whole "early maternal environment," and to what it includes—from the infant's point of view—as he experiences it. We now understand that this "early maternal environment" includes not only the mother herself, but also a great variety of literal and symbolic substitutes for her. Thus, any person who takes the mother's place in caring for the infant is experienced as "mother"—whether the person actually happens to be the nurse, grandmother, aunt, sibling, baby-sitter, or even the father. It may seem strange to view "father" as a mere substitute for "mother"; but how could the infant view him otherwise? The infant has no way of knowing that Western society is patriarchal. And the infant has no way of knowing that Freud and other psychologists have focussed on the father as the key figure in the emotional development of children. From the infant's point of view, everything other than himself is "mother." In this sense, even the father is a "mother." In the same sense, the symbolic substitutes for "mother" can include the electric light bulb which the infant sees, the air he breathes, the blanket which he chews, the urine which soaks his diaper and irritates his skin, and so on.

Our approach to this understanding of the "early maternal environment" has been gradual. One of our earliest formulations was presented in a paper on "Some Etiological Concepts with a Verbatim Case Report on the Application of the Direct Analytical Method" [1947], which was subsequently revised and published as "The Perverse Mother" [1953]. The paper dealt with the idea that there is a "maternal instinct," and that this instinct can be "perverted" just as any other instinct can be, according to the developmental deviations which Freud originally described.[1] On subsequent occasions, we reiterated these views and elaborated them with regard to the problems of treating deeply psychotic individuals.[2] Most recently, in *Direct Psychoanalytic Psychiatry*

[1962], we have given a detailed description of the ways in which the psychiatrist can make use of the "early maternal environment" concept as a guide to the treatment of psychotics.[3]

The present paper will be more concerned with theory than with treatment. We are taking this occasion to state our current views on the whole subject of the "early maternal environment." We will try to bring together, here, the major considerations which have led us to our understanding of it; and we will try to show how the "early maternal environment" concept can illuminate the origins, the progress, and the symbolic content of neurosis and psychosis. We will say relatively little, here, about the more technical aspects of treatment; but we will be referring to clinical experience as a source of documentation of our views, and we will touch upon what might be called the "philosophy" of treatment as the direct psychoanalyst understands it.

As a contribution to the literature of psychoanalytic psychiatry, this paper may seem to contradict or to deviate from the views of Freud, Abraham, and other pioneers. For instance, in pursuing our understanding of the "early maternal environment" and its influence on the child's development, we have put relatively more emphasis on the oral stage, and relatively less emphasis on the genital stage, than did Freud and his immediate followers. We have been led to make this shift of emphasis by our clinical experience with both psychotic and neurotic individuals—especially with psychotics, whose "manifest content" seems to be much more intelligible at the oral and anal [pre-genital] levels than at the genital level. And we believe that Freud himself preferred to be guided by the clinical material of his psychoanalytic practice, even if it required him to change his views from time to time. He stated once that his understanding of neurosis was "nothing but the result of continued and constantly extended experience; for anything that arises from speculation may very easily appear once for all complete in form and then remain unalterable."[4] On another occasion, Freud said: "As to the right to change our opinions. if we think that we have found something better, we have made full use of it in psychoanalysis."[5] In direct psychoanalysis, we try to uphold this truly scientific tradition.

The clinically-oriented reader, who has perhaps been more interested in the technical aspects of direct psychoanalysis than in its theoretical aspects, will find in this paper that the technical procedures are inter-dependent with the theory—in which the concept of "early maternal environment" is central. He may need to be reminded, also, of the subtleties involved in this concept. Occasionally we hear of a psychiatric resident or even of a more seasoned psychiatrist, who has seemingly misconstrued or over-simplified the "maternal" aspects of the direct psychoanalyst's role in treatment. A typical misconstruction or over-simplification would be to sit a mute "catatonic" individual on one's lap and to feed him with a nursing bottle, while the phonograph plays lullabies in the background. Another such procedure would be to ply a "depressed" psychotic with pretty jelly-beans, in hopes of making restitution for the inadequacies of a "bad mother." As ludicrous as they are, some incidents of this kind have been reported to us. Is it not obvious that effective psychiatry must be more than "a playful game between mother and child"?[6] And is it not obvious that effective mothering, in the "early maternal environment," includes more than feeding? Even now, we are only beginning to perceive and comprehend the complexities of the child's relationship with his early maternal environment. The nutritional relationship of mouth and breast or mouth and bottle is but one segment of the whole constellation. As our work goes forward, we are able to discern and to understand more of the segments of this constellation, and we find that it is an exciting search, for all of its difficulties. But we realize that there are still many gaps, and many provisional "x-factors," in our knowledge of the early maternal environment and of "mothering."

This paper undertakes to make clear that "mothering"—whether malevolent or benevolent—is far more subtle and complex than what we see in the mere feeding and cuddling of an infant.

ABSTRACT OF THE PAPER

This paper has four main parts. The first part, A FREUDIAN VIEW OF PSYCHOSIS, discusses the basic proposition that psychosis is a psychical difficulty and not a disease entity. We agree, in substance, with Freud's "proposition that neuroses and psychoses originate in the ego's conflicts with the various powers ruling it."[7] We would agree, also, with Freud's suggestion of the similarity of psychosis to dreams and nightmares.[8] In our view, psychosis—like the dream and the nightmare—indicates a regression to the infantile stages of psychosexual development. We have observed many features of psychotic behavior which indicate that an individual may regress as far as the neo-natal experience, the earliest segment of the oral stage, although he may still show some traces of anal or even of genital development; regression, like psychosexual progression, is never a complete transition from one stage to another. As Freud said of these stages, "one of them may appear in addition to another, they may overlap one another, they may be present simultaneously."[9] Consequently, with a psychotic individual who is chronologically adult, we have an opportunity to study his reactions at many different developmental levels. Most importantly—from our point of view—we can study his original reactions to the early maternal environment, as he is re-experiencing them; for now his needs and frustrations are expressed in language which is frequently intelligible to us, in contrast with the primitive cry of the actual infant.

Part I continues with our current definition of the "early maternal environment" concept and a discussion of some of its implications.

The second main part of this paper, THE EARLY MATERNAL ENVIRONMENT IN PSYCHOSIS, demonstrates how this concept is useful to the psychiatrist in three different ways. *First*, the concept is useful in understanding psychosis as a whole, despite the variations in manifest content among different psychotic individuals, and despite manifest variations in the same individual over a period of time. Broadly speaking, we regard psychosis as a re-experiencing of the early maternal environment. The manifest content of psychosis, including the individual's

so-called "bizarre" or "unintelligible" talk, provides us with clues to the individual's original experiences and reactions. *Second,* we use the concept of "early maternal environment" to help us differentiate and characterize the different *phases* of psychosis. By "phases," we mean certain fairly distinct patterns of behavior, mood, and thought. As far as we have been able to determine, these phases have a definite sequence of occurrence, according to an individual's "downward" [regressive] or "upward" [progressive] movement within the pre-genital stages of development. In essence, we regard these phases of psychosis as differing reactions of the individual [ego] to the unconscious representative of the early maternal environment [superego] which is forever influential in his development or his failure to develop.[10] The phases of psychosis, then, may be regarded as neo-infantile reactions to "mothering," i.e., to the activities of the early maternal environment.[11] *Third,* we use the "early maternal environment" concept to explain particular items of a psychotic's behavior; in earlier publications we have illustrated this use of the concept with examples drawn from the direct psychoanalytic treatment of psychotics.[12]

The third main part of this paper is called, DIRECT PSYCHOANALYSIS ATTEMPTS TO COMPENSATE FOR THE INADEQUACIES OF THE EARLY MATERNAL ENVIRONMENT. We try to provide the psychotic individual with a therapeutic environment which will offset the deficiencies or excesses of his early maternal environment, however it manifested itself originally by doing too much or too little for him. The therapeutic environment of direct psychoanalysis includes the "treatment unit," an individual home especially modified for this use, and it also includes the "assistant therapists," who live in the treatment unit with the psychotic individual and follow the program prescribed by the direct psychoanalyst. This therapeutic environment serves as a context for the direct psychoanalyst's role of "foster-mother."[13] And, when an individual emerges from psychosis into the partial maturity which we designate as "neo-neurosis," then the therapeutic environment continues to be available to him as he needs it, and the direct psychoanalyst continues in the role of the "foster-mother," modifying it in ways appropriate to the individual's increasing maturity.[14]

The fourth and final part of this paper is called, THE EARLY MATERNAL ENVIRONMENT IN THE CHILD'S DEVELOPMENT. Our understanding of the child's difficulties with his early maternal environment is derived mainly from the clues available in the manifest content of the neo-infantile psychotic. We are not primarily concerned with the psychology of childhood, and we are not engaged in the study of infants in the nursery, as some of our colleagues are. We consider such work to be as important as ours, and to be complementary to our work; for the child psychologist observes the infant and conjectures about his fate as an adult, while we observe the adult psychotic and conjecture about his experiences as an infant. When they are put together, the observations of the child psychologist and of the direct psychoanalyst provide a fairly continuous reconstruction of the psychotic individual's "abnormal development."[15] In this reconstruction, we trace the growth of the individual's superego, which we regard as being essentially a psychical representative of the early maternal environment. And we describe the individual's life-long tendency to "seek the mother he knew," not only in the sense of ego-superego harmony, but also in the sense of harmony with the world around him. Here we make use of such Freudian concepts as "identification" and "transference." However, we put most of the emphasis upon maternal influence, where Freud emphasized the influence of the father.

I. A FREUDIAN VIEW OF PSYCHOSIS

When we say that direct psychoanalysis takes a Freudian view of psychosis, we mean minimally that psychosis is psychogenic. It is like a relentless dream or nightmare, and so it can be understood in the same way that the psychoanalyst would understand a dream or a nightmare.[16] It has manifest content—which may include the totality of the individual's verbal and non-verbal behavior—and latent content which we have come to understand in terms of the "early maternal environment" concept.

Relatively few psychiatrists hold this view of psychosis. Of those who do hold it, very few seem to practice psychotherapy in accordance with the theory which they preach. For instance, the late Edward A. Strecker once said:

> In many schizophrenic patients a true bill of indictment can be drawn against mom [Strecker's term to designate the so-called "bad mother"]—indictment for failure to prepare the child to meet the minimal demands of adult life. . . . There is little doubt that schizophrenia qualifies as a mom surrogate.[17]

But Strecker did not indicate what this view of psychosis implies for the psychiatrist who is attempting to remedy the situation through psychotherapy. For another instance, S. R. Slavson states: "It has long been recognized that mothers are the greatest single factor in the emotional maladjustment of children."[18] But Slavson gives little indication of how psychotherapy can be specifically directed to deal with this maternal factor.

The present paper will undertake to show how our Freudian view of psychosis is closely related to the method of psychiatry which we call "direct psychoanalysis."

To begin with, it should be entirely clear that we do not regard psychosis as being a disease entity in the medical sense. Psychosis is psychogenic. It can be compared to the panic and terror we would observe if someone yelled *"Fire!"* in a crowded theatre. We could not appropriately refer to this state of panic and terror as "having a disease." Similarly, we would not say that a baby is "diseased" when it screams in terror with the unabating hunger, thirst, cold, or loneliness resulting from the absence of the maternal holding and caress. And we maintain that it is equally inappropriate to describe the psychotic individual as afflicted with a "disease."

In treatment, therefore, it is not enough to deal with the psychotic's panic and terror through the use of insulin-shock, electro-shock, tranquilizers, morphine, alcohol, or any other deadener of emotional reactions. These "deadening" procedures may be preferable to some of the older procedures for dealing with psychosis, such as burning the individual at the stake, chaining him in a dungeon, burying him in a Bedlam, and the like. It is a step forward to move from killing the pained individual—because he may be a social nuisance—to killing his pain. The next step is to regard to psychotic's "pain" not as an end in itself, but as a clue to some psychical distress which can be alleviated through understanding and the governing principle, the "foster-mother" principle, of direct psychoanalysis.

We do not deny that there are important somatic concomitants of emotional distress; for instance, the chemical and endocrine changes which have received so much attention in recent years. Every emotional change may have its somatic aspects. Thus we may observe an individual whose face is pale, whose hands are cold and sweating. We may know that his pallor and the coldness of his hands are the results of the constriction of certain blood-vessels, yet we recognize his emotional state as *fear,* and we would not say that he became frightened because these blood-vessels constricted. If we would not say this of the "normal" person who appears frightened, then why should we say it of a psychotic?

Similarly, we do not deny that certain genetic factors may predispose an individual towards psychosis; however, there is no convincing evidence that such a predisposition exists. Even if we were to assume that it does exist, how would this assumption guide us in designing and utilizing a method of treatment? All too often, theory and treatment are very tenuously related. For instance, some of those psychiatrists who advocate insulin-shock treatment maintain that psychosis is "a hereditary disease in which one finds abnormal cells in the cerebral cortex. These are destroyed by anoxia [oxygen deficiency] as a result of the insulin coma treatment."[19] Since the patient's brain-tissue can be examined only *post mortem,* when the condition of the cells cannot be positively attributed to any particular aspect of the psychosis or of the treatment, there is no way of substantiating this theory with neurophysiological fact. Freud, reflecting on his own experience in neurophysiology, once expressed a view with which we would concur.

> The medulla oblongata is a wondrous and beauteous object; I well remember how much time and labour I devoted to the study of it years ago. But to-day I must say I know of nothing less important for the psychological comprehension of anxiety than a knowledge of the nerve-paths by which the excitations travel.[20]

Psychosis, Dreams, and Nightmares

Over the whole course of his psychoanalytic career, Freud maintained the conviction that psychosis, dreams, and nightmares are essentially similar; ultimately he said that a dream *is* a psycho-

sis.[21] We say that a psychosis is not only similar to dreams in general, but closely related to the protracted and relentless nightmare, in particular. A dream has among its purposes the guarding of sleep. For the healthy infant, sleep follows *feeding*—which is perhaps the producer of sleep. A peaceful dream will keep the sleeper asleep in much the same way that feeding and the warm breast are sleep-producing and sleep-protecting for the infant. The dream which is not peaceful, i.e., the nightmare, does not usually keep the sleeper asleep. Perhaps the "un-peacefulness" of nightmares and of psychosis can be attributed to an early maternal environment which does not have the qualities of the nourishing, comforting, sleep-producing breast.

There are sweet dreams of lovely gardens, beautiful hilly landscapes, and serene lakes, with softened air to suck on. In contrast to these are the nightmarish terrors in a dream of being cornered and eaten by lions—which we would interpret as the talionic reprisal for the infant's cannibalistic oral hostility towards the breast which frustrated and agonized him. Psychosis has nightmarish qualities. An example is the manifest fear of being poisoned by food, which we observe frequently in so-called "paranoid" psychotics. We regard such manifest content as disguising a latent fear, infantile in origin, of being harmed by some "poisonous" aspect of the early maternal environment. Since milk and food are so important to the infant, it seems reasonable that a psychotic would refer to them in his concretistic descriptions of the oral harm he fears, while re-experiencing the early maternal environment.

In treating psychotics, we have found extensive parallels between psychosis and dreams or nightmares. Psychosis has distinct layers of manifest content and latent content, just as the dream or nightmare does. The manifest content of psychosis makes use of certain realistic details from everyday experience, just as the manifest content of the dream or nightmare makes use of realistic day-residue. For instance, the psychotic individual who is hearing hallucinatory "voices" may explain that they come to him through the radio or television. In an earlier era, the explanation might have referred to the telegraph system as the means of transmitting these "voices" and their messages. The latent con-

tent of psychosis, like the latent content of the dream or nightmare, includes a number of regressive, infantile wishes and fears. The object of these wishes and fears is the early maternal environment.

In the direct psychoanalytic treatment of a psychotic individual, we make use of interpretations, just as a conventional psychoanalyst would do in the treatment of a neurotic individual. Occasionally, the very same interpretation might be appropriate in either situation, since the basic function of interpretations is simply to make conscious a thought or feeling which has been unconscious until now. But as a rule, it is more appropriate to make interpretations at the oral level, when treating a psychotic, and to make them at the genital level when treating a neurotic. This difference follows from the relative difference in levels of maturity: the regressed psychotic individual is oriented mostly at the oral level, while the neurotic individual is oriented mostly at the genital level. As we observed earlier, no individual is likely to be oriented entirely at any one level; even the most mature individuals have some remnants of immaturity in them, and even the least mature individuals have not—in regression—forsaken their maturity altogether. We might make a similar point in regard to dreaming and being awake: probably no dreamer is entirely absorbed in his dreaming, but has some slight amount of attention for the external environment; and probably no ambulatory person is entirely awake, but has some slight amount of preoccupation with his internal environment.

One further point to be noted is that there are differences between the psychosis and the dream or nightmare. While the manifest content of a dream may be limited to what the individual can consciously retain long enough to report to his psychoanalyst, the manifest content of psychosis seems to include nearly all of the psychotic's behavior—whether or not he is ever capable of describing or reporting it to someone else. Another difference is that, while a neurotic individual may participate in his own psychoanalysis to the extent of helping to interpret his dreams and his other behavior, the psychotic individual is more likely to seem disinterested in treatment—to be preoccupied with the continuing panorama of his regressive experience with the

early maternal environment. A further difference is that the psychoanalysis of a neurotic may deal with much besides the manifest content of his dreams, while the direct psychoanalysis of a psychotic can deal with little else besides the manifest content of the psychosis, through which the latent content is gradually exposed.

Regression to Infancy in Psychosis

As we indicated in the Introduction to this paper, one can learn a great deal about the early maternal environment by giving close and continuous attention to the verbal and non-verbal behavior of psychotics. When Freud revised *The Interpretation of Dreams,* in 1909, he added the following statement: *"The interpretation of dreams is the royal road to a knowledge of the unconscious activities of the mind."*[22] We have stated elsewhere,[23] and will reiterate here, that the study of psychosis is an even better means of access to such knowledge. Freud said:

> Dreaming is on the whole an example of regression to the dreamer's earliest condition, a revival of his childhood, of the instinctual impulses which dominated it and of the methods of expression which were then available to him.[24]

But the ordinary dream is brief, fragmentary, and difficult for the individual to retain long enough to report to his psychoanalyst. The psychotic's "dreaming" is continuous and conspicuous; the psychiatrist can study it directly, and can even participate in it, through his "therapeutic dialogue" with the individual. The unconscious activities of the adult's mind are, to a large extent, the same as those of the infant's mind. In the adult's dreams, these activities are momentarily closer to consciousness. In psychosis, these activities become dominant again; but the neo-infantile psychotic, unlike the normal dreamer or the infant, tries again and again to describe and express these activities in language which eventually becomes intelligible to us. From the normal dreamer, we may hear only a few disjointed words or sentences; from the infant, we will hear only the anguished cry or the happy gurgle. Hence we say that the psychotic is the one who makes the unconscious, internal environment most accessible to us.

Freud's dream-psychology is indispensable to our understanding of the regressed psychotic individual. We have found that the psychotic makes use of symbolism, condensation, and displacement, in the same way that the dreamer does. And we have noted that certain ingredients of day-residue are utilized in psychosis, just as they are utilized in dreams. To some extent, our work along these lines has been anticipated by Bleuler,[25] Jung,[26] and other psychiatrists who appreciated the applicability of Freud's dream-psychology to psychosis.[27] However, we have found it necessary to go beyond the piecemeal interpretation of various psychotic manifestations, and to search for unifying themes or factors at the level of latent content. Freud said that the "return to the first incestuous objects of the libido is a feature found with quite fatiguing regularity in neurotics."[28] We have located the equivalent feature in psychotics. In every instance, their manifest content—from "somebody put cement in the scrambled eggs" and "this food is poisoned" to slips-of-the-tongue such as "murder-in-law"—leads us to the latent content of "mother" and "breast." We view this latent content more broadly as the early maternal environment.

A Definition of the "Early Maternal Environment" Concept

Although first-hand studies of mothers and infants might yield any number of descriptions and definitions of "mothering" from an observer's point of view, the infant himself is not available for comment. The closest we can come to an interview with an infant is a dialogue with a "neo-infant," i.e., a psychotic who has not regressed entirely beyond the use of language. Since our main interest is in the treatment of psychotics, we are willing to accept the psychotic's descriptions of his early maternal environment, however biassed and distorted his view of it may be. After all, it is *his* estimate of "mother" which is important to him, rather than any outsider's estimate of the performances of the actual mother and the various substitutes for her.

We learn from the psychotic that the early maternal environment includes three kinds of components; first, the actual mother —if and when she is available to the infant; second, the relatives